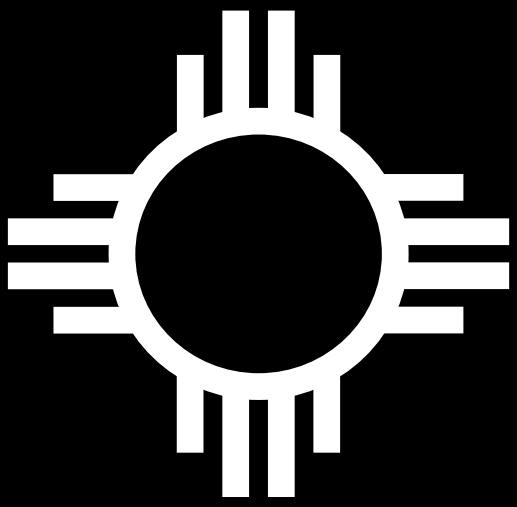
NEW MEXICO REGISTER



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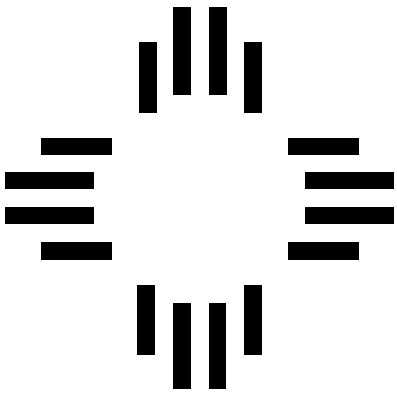

The official publication for all notices of rulemaking and filings of adopted, proposed and emergency rules in New Mexico

The Commission of Public Records
Administrative Law Division
Santa Fe, New Mexico
2004

New Mexico Register

Volume XV, Number 12
June 30, 2004

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Effective Date and Validity of Rule Filings

Rules published in this issue of the New Mexico Register are effective on the publication date of this issue unless otherwise specified. "No rule shall be valid or enforceable until it is filed with the records center and published in the New Mexico register as provided by the State Rules Act. Unless a later date is otherwise provided by law, the effective date of a rule shall be the date of publication in the New Mexico register." Section 14-4-5 NMSA 1978.

A=*Amended*, E=*Emergency*, N=*New*, R=*Repealed*, Rn=*Renumbered*

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Notices of Rulemaking and Proposed Rules

NEW MEXICO PUBLIC ACCOUNTANCY BOARD

PUBLIC ACCOUNTANCY BOARD
NOTICE OF PROPOSED
RULEMAKING

The New Mexico Public Accountancy Board ("Board") will convene a public hearing on Friday, July 9, 2004. The hearing will be held at 9:00 a.m. in the New Mexico Society of CPAs Conference Room, 1650 University Blvd. NE, Suite 450, Albuquerque, New Mexico. Notice of the meeting is given in accordance with the Board's Open Meetings Policy. The hearing will be held for the purpose of affording members of the public the opportunity to offer comments on proposed amendments to existing Board rules. The hearing will be followed by a regular Board meeting in the same location.

The Board staff will recommend that the Board adopt amendments to the following rules:

NMAC NUMBER	RULE NAME
16.60.1 NMAC	General Provisions
16.60.2 NMAC	Certified Public Accountant (CPA) Examination Requirements
16.60.3 NMAC	Licensure and Continuing Professional Education Requirements

Notice of the hearing and Board meeting has been published in the New Mexico Register and in the Albuquerque Journal. Interested parties may access the proposed amendments on the Board's website at www.rld.state.nm.us/b&c/accountancy. Copies may also be obtained by contacting the Board office at (505) 841-9108. Written comments regarding the proposed amendments should be directed to Ms. Patricia Soukup, Executive Director, Public Accountancy Board, 111 Lomas NW, Suite 510, Albuquerque, New Mexico 87102 or faxed to (505) 222-9155. Comments must be received by 5:00 p.m. on Wednesday, July 7, 2004; however, the submission of written comments as soon as possible is encouraged.

Individuals with disabilities who require this information in an alternative format or need any form of auxiliary aid to attend or participate in this meeting should contact the Board office at (505) 841-9108 by 5:00 p.m. on July 2, 2004.

NEW MEXICO DEPARTMENT OF FINANCE AND ADMINISTRATION

LOCAL GOVERNMENT DIVISION

Legal Notice of the Public Hearing on the Small Cities Community Development Block Grant Regulations

Local Government Division, Department of Finance & Administration
Suite 202, Bataan Memorial Building
Santa Fe, New Mexico 87501

Date: June 16, 2004
Release Date: For Immediate Release
Contact: Sam L. Ojinaga, CDBG Bureau Chief (827-8073)
Reference: Hearing on Small Cities Community Development Block Grant

Local Government Division, CDBG Program, will hold a public hearing regarding the adoption of the Small Cities Community Development Block Grant Regulations on Monday, August 2, 2004 from 10:00 a.m. to 12:00 p.m. at the Department of Education, Mabry Hall, 300 Don Gaspar, Santa Fe, New Mexico 87501.

The purpose of the public hearing is to receive public comment on adoption of the revised Small Cities Community Development Block Grant Regulations, 2.110.2 NMAC. The proposed rule and proposed amendments can be found at: www.nmlocalgov.net.

Copies of the proposed rule and regulation can be obtained at the Department of Finance & Administration, Local Government Division web site at: www.nmlocalgov.net. Interested individuals may testify at the public rules and regulations hearing and/or may submit written comments no later than 4:00 p.m., July 28, 2004, to Local Government Division, Room 202, Bataan Memorial Building, Santa Fe, New Mexico 87501, or email to SOjinaga@state.nm.us. All written and oral testimony will be considered prior to issuance of the final rules and regulations.

If you are an individual with a disability who is in need of a reader, amplifier, qualified sign language interpreter, or any other form of auxiliary aid or services to attend or participate in the hearing or meeting, please contact Sam L. Ojinaga, Local Government Division at (505) 827-8073. The Department of Finance and Administration requests at least ten (10) working days advance notice to provide requested alternative formats and/or special accommodations.

NEW MEXICO NAPRAPATHIC PRACTICE BOARD

Legal Notice

Notice is hereby given that the New Mexico Naprapathic Practice Board will convene a Rule Hearing to adopt the following rules:

16.6.1 NMAC	General Provisions
16.6.2 NMAC	Code of Conduct
16.6.3 NMAC	Fees
16.6.4 NMAC	License Expiration and Renewal
16.6.5 NMAC	Inactive Status
16.6.6 NMAC	Continuing Education
16.6.7 NMAC	Licensure by Endorsement
16.6.8 NMAC	Practice Procedures
16.6.9 NMAC	Supervision of Interns
16.6.10 NMAC	Naprapathic Assistants
16.6.11 NMAC	Parental Responsibility Act

This Hearing will be held at the State of New Mexico Regulation and Licensing Department, 2550 Cerrillos Rd., Second floor, Santa Fe, NM, on July 30, 2004 at 10:00 a.m.

Following the Rule Hearing the New Mexico Naprapathic Practice Board will convene a regular meeting.

Copies of the proposed rules are available on request from the Board office, P. O. Box 25101, Santa Fe, New Mexico, 87504-5101, or phone (505) 476-4600.

Anyone wishing to present their views on the proposed rules may appear in person at the Hearing, or may send written comments to the Board office. Written comments must be received by July 15, 2004 to allow time for distribution to the Board members. Individuals planning on testifying at the hearing must provide copies of their testimony also by July 15, 2004.

Copies of the agenda will be available 24 hours in advance of the meeting from the Board office.

Disabled members of the public who wish to attend the meeting or hearing and are in need of reasonable accommodations for their disabilities should contact the Board office at (505) 476-4600, no later than July 15, 2004.

NEW MEXICO STATE FAIR COMMISSION

NOTICE OF PUBLIC RULEMAKING HEARING

Notice is hereby given that the New Mexico State Fair Commission will hold a public rulemaking hearing on **Monday, August 16, 2004, beginning at 1:30 p.m. at the African-American Pavilion, New Mexico State Fairgrounds, 300 San Pedro, NE, Albuquerque, NM.**

The purpose of the meeting is to receive comments on proposed amendments to the following regulation: 4.3.11 NMAC – State Fair Open Air Market Rules and Regulations. Any person who is or who may be affected by these proposed rules may appear and testify at the meeting. Those requesting to testify should contact Roberta Simoni by e-mail, preferably, at rsimoni@exponm.com, or via phone at 505-265-1791, or by mail at the New Mexico State Fair Commission, P.O. Box 8546, Albuquerque, NM 87198, on or before Thursday, August 5, 2004 at noon. Written comments on proposals should be submitted to Ms. Simoni on or before Thursday, August 5, 2004 at noon. Persons with disabilities who need accommodations (such as sign language interpretation, a reader or an amplifier) to attend or participate should contact Ms. Simoni at 505-265-1791. The New Mexico State Fair Commission proposes to adopt the following regulations:

End of Notices and Proposed Rules Section

Adopted Rules

NEW MEXICO BOARD OF BARBERS AND COSMETOLOGISTS

This is an amendment to 16.34.1 NMAC, Section 7, effective July 16, 2004.

16.34.1.7 DEFINITIONS: As used in the Barbers and Cosmetologists Act:

A. "applicant" means a person who has applied for a license;

B. "approval number" means the number assigned by the board to designate an approved provider;

C. "approved" means accepted as a provider by the board;

D. "barber" means a person, other than a student, who for compensation engages in barbering;

E. "barbering" means shaving or trimming the beard or cutting the hair, curling and waving, including permanent waving, straightening the hair, giving facial and scalp massage or treatments with oils, creams, lotions or other preparations, either by hand or mechanical appliances, shampooing, bleaching or dyeing the hair or applying tonics or applying cosmetic preparations, antiseptics, powders, oils, clays or lotions to the scalp, face, neck or upper part of the body, caring for and servicing wigs and hair pieces or removing of unwanted hair except by means of electrology;

F. "board" means the board of barbers and cosmetologists;

G. "booth establishment license" means a license required of an individual who rents space within another licensed establishment for the purpose of rendering licensed services as a separate, independent business.

H. "branch campus/additional location" the board does not recognize branch campuses or additional locations in the same manner as some accrediting agencies or the US department of education; a school may be approved by other such oversight agencies as a "branch" or an "additional location;" however, they must be approved by the board as a separate school with a stand-alone license;

I. "contact hour" means one contact hour equals a minimum of fifty minutes of instruction;

J. "cosmetologist" means a person, other than a student, who for compensation engages in cosmetology;

K. "cosmetology" means arranging, dressing, curling, waving, cleansing, cutting, bleaching, coloring, straightening or similar work upon the hair of a person, whether by hand or through the use of chemistry or of mechanical or electrical apparatus or appliances, using cosmetic preparations, antiseptics, tonics, lotions or creams or massaging, cleansing, stimulating, manipulating, beautifying or performing similar work on the body of a person, manicuring and pedicuring the nails of a person, caring for and servicing wigs and hair pieces or removing of unwanted hair except by means of electrology;

L. "current work experience" means verified work that has occurred within the previous five years;

[~~M. "demonstrator" means a person who may not hold a current license in this state or any state who demonstrates a product or technique for the sole purpose of promoting and/or retailing the product or technique to the public, members of the profession and their clients, renders services only incidental to the promotion of the product or technique and receives no compensation of any kind from the subject (model) in connection with the promotion, although compensation may be received from the licensees or sponsors of such demonstrations;~~]

[~~N.~~]M. "electrologist" means a person, other than a student, who for compensation removes hair from or destroys hair on the human body through the use of an electric current applied to the body with a needle-shaped electrode or probe;

[~~O.~~]N. "enterprise" means a business venture, firm, or organization

[~~P.~~]O. "expansion campus facility" means any separate classroom or clinic used for educational purposes that is separate, detached and apart from the primary facility and main address; its purpose is to allow the licensed school to provide adequate space to train students who are enrolled through the primary facility;

[~~Q.~~]P. "establishment" means an immobile beauty shop, barbershop, electrology clinic, salon or similar place of business in which cosmetology, barbering or electrolysis is performed;

[~~R.~~]Q. "esthetician" means a person, other than a student, who for compensation uses cosmetic preparations, including makeup applications, antiseptics, powders, oils, clays or creams or massaging, cleansing, stimulating or manipulating the skin for the purpose of preserving the health and beauty of the skin and body or performing similar work on any part of the body of a person;

[~~S.~~]R. "executive director" means the director for the board;

[~~T.~~]S. "guest artist" means a non-resident who is granted permission to promote a product or technique in New Mexico for a limited time in accordance with rules adopted by the board;

[~~U.~~]T. "HSD" means the New Mexico human services department;

[~~V.~~]U. "instructor" means a person licensed to teach in a school of cosmetology, barbering or in a school of electrology;

[~~W.~~]V. "license" means a certificate, permit or other authorization to engage in each of the professions and occupations regulated by the boards enumerated in Subsection A of the Act;

[~~X.~~]W. "main campus" means a school, which has been licensed by the board for the three most recent years; any change in location of the main campus must comply with the procedures set forth in 16.34.8 NMAC of these rules; the main campus includes the primary facilities and any separate or detached expansion campus facility of the primary training site;

[~~Y.~~]X. "manicurist-esthetician" means a person, other than a student, who for compensation performs work on the nails of a person, applies nail extensions or products to the nails for the purpose of strengthening or preserving the health and beauty of the hands or feet and who uses cosmetic preparations, including makeup applications, antiseptics, powders, oils, clays or creams or massaging, cleansing, stimulating or manipulating the skin for the purpose of preserving the health and beauty of the skin and body or performing similar work on any part of the body of a person;

[~~Z.~~]Y. "manicurist-pedicurist" means a person, other than a student, who for compensation performs work on the nails of a person, applies nail extensions or products to the nails for the purpose of strengthening or preserving the health and beauty of the hands or feet;

[~~AA.~~] Z. "manicurist-shampooer" means a person who for compensation performs work on the nails of a person, applies nail extensions or products to the nails for the purpose of strengthening or preserving the health and beauty of the hands or feet and practices the art of shampooing, application of conditioners, rinses and scalp manipulations to the hair and scalp of a person and on artificial hair;

[~~BB.~~] AA. "outreach enterprise" means an independent mobile unit, or system of units, equipped with or carrying both professional and special equipment used by a professional licensee of this act to a site or premises for the purpose of providing professional services to the handicapped, restricted, homebound, impaired, incapacitated, delicate, or otherwise constrained client.

[~~CC.~~] BB. "provider" means the person, firm, corporation, institution or agency approved to conduct or spon-

sor a continuing education program and ensure its integrity;

[~~DD.~~] CC. "revoke a license" means to prohibit the conduct authorized by the license;

[~~EE.~~] DD. "sanitation" means the maintenance of sanitary conditions to promote hygiene and the prevention of disease through the use of chemical agents or products;

[~~FF.~~] EE. "school" means a public or private instructional facility approved by the board that teaches cosmetology or barbering;

[~~GG.~~] FF. "[~~state~~] statement of compliance" means a certified statement from HSD stating that an applicant or licensee is in compliance with a judgment and order for support;

[~~HH.~~] GG. "statement of non-compliance" means a certified statement from HSD stating that an applicant or licensee is not in compliance with a judgment and order for support.

[~~II.~~] HH. "student" means a person enrolled in a school to learn or be trained in cosmetology, barbering or electrolysis;

[~~JJ.~~] II. "suspend a license" means to prohibit, for a stated period of time, the conduct authorized by the license; "suspend a license" also means to allow for a stated period of time the conduct authorized by the license subject to conditions that are reasonably related to the grounds for suspension;

[~~KK.~~] JJ. "temporary license" means a person, not licensed, who engages in the occupation of or teaches barbering, cosmetology or electrology by authority granted under special permission of the board; and

[~~LL.~~] KK. "verified work experience" means work experience in the applicable discipline in a licensed establishment, enterprise or electrology clinic as verified by:

(1) certified and notarized statement by employer(s);

(2) certified and notarized statement by licensed co-worker(s);

(3) certified and notarized statement by client(s);

(4) certified and notarized copies of tax returns;

(5) certified and notarized copies of W-2's; or

(6) other related form(s) of documentation.

[16.34.1.7 NMAC - Rp 16 NMAC 34.1.7, 06-16-01; A, 07-16-04]

NEW MEXICO BOARD OF BARBERS AND COSMETOLOGISTS

This is an amendment to 16.34.2 NMAC, Section 8, effective July 16, 2004.

16.34.2.8 GENERAL LICENSING PROCEDURES

A. Application forms

(1) Application for any license to be issued or renewed by the board shall be made on the official form provided by the board for that purpose. Applications must include the required fee in the form of a money order, cashier's check or business check, (no personal checks will be accepted). Incomplete applications will be returned. Designated deadlines will apply to resubmitted applications.

(2) Applications for licensure must include:

(a) proof of age includes a copy of a birth certificate, a driver's license or a state issued identification card, or a baptismal certificate;

(b) proof of applicable secondary education includes a high school diploma, a G.E.D. certificate or transcript of G.E.D. test scores, a letter from the high school attended containing the school seal, a copy of the high school transcript showing all required grades have been passed, a letter from the G.E.D. testing facility stating that the G.E.D. test has been passed or any other test approved by the United States department of education for the purpose of determining an applicant's ability to benefit, providing that documentation of grade equivalency is established by the test publisher and the required grade level for licensure has been achieved; documents submitted in a language other than English must be accompanied by a notarized translation of the document;

(c) the board, or its executive director, may accept as proof of secondary education the applicants notarized statement that he/she has completed the required secondary education, but has been unable to obtain documentary proof of that from a foreign nation; a notarized statement will not be accepted for applicants who have completed the secondary education in the United States;

(d) a transcript of hours showing that the training hours were completed within the preceding twenty-four months.

B. Photographs

(1) Applicants for original licensure by the board shall submit a recent (within three months), front-view, head only photograph of him/herself. The photo must me at least 1.5" X 1.5" and no larger than 2" X 3".

(2) Licensees must attach a recent (within three months), (front-view, head only photograph of him/herself) to the license when it is issued and sign the license. The photo must be at least 1.5" X 1.5" and no larger than 2" X 3".

(3) Licensees must present a driver's license or other identification when requested by the public, the board or its authorized representative.

C. Renewals

(1) Timely renewal of license(s) is the full and complete responsibility of the LICENSEE. Failure to renew the license by the expiration date will result in late fees or reexamination as set forth in the act.

(2) If a licensee has held a valid practitioner or instructor license within the previous twelve months, the instructor license may be used to renew or reinstate the original practitioner license.

(3) The board will issue renewal licenses within fifteen working days of receipt of the renewal request and applicable fee.

(4) Timely renewal of an establishment, enterprise, electrology clinic and school license is the full and complete responsibility of the LICENSEE. Failure to renew the license within thirty days after its expiration, payment of the renewal fee and a late fee will be required.

D. For the purpose of meeting deadlines for submission of applications or required documentation, facsimiles may be accepted at the discretion of the boards executive director.

[16.34.2.8 NMAC - Rp 16 NMAC 34.2.8, 06-16-01; A, 07-16-04]

NEW MEXICO BOARD OF BARBERS AND COSMETOLOGISTS

This is an amendment to 16.34.3 NMAC, Section 9 and 11, effective July 16, 2004.

16.34.3.9 EXAMINATION SCORES

A. The minimum passing score for all written and practical licensing examinations is seventy five percent.

B. Examinations for all licenses except instructor licenses are scored in three individual segments, each requiring a minimum segment score of seventy five percent. The segments are:

(1) practical;

(2) theory written; and

(3) state law written.

C. If an applicant fails to attain a seventy five percent score on any segment of the written examination, he/she will be required to retest in the failed segment(s) only and achieve a passing score.

D. If an applicant fails to attain at least a seventy five percent score on the practical segment of any practical examination, he/she will be required to retest in the failed subject(s) only (both critical and non-critical core) and achieve a passing score.

[~~E. If an applicant passes the practical segment of the examination with a seventy-five percent or better score, but fails to attain the required score in any of the critical core subjects of the practical examination, he/she will be required to retest in the failed subject(s) only and achieve a passing score.~~]

[~~F.~~] E. Examination for instructor licenses for all disciplines are scored in two individual segments, each requiring a minimum score of seventy five percent. The segments are:

(1) theory written; and

(2) state law written.

[16.34.3.9 NMAC - Rp 16 NMAC 34.3.9, 06-16-01; A, 07-16-04]

16.34.3.11 EXAMINATIONS FOR EXPIRED LICENSES AND FAILED EXAM APPLICANTS

A. Applicants whose license has expired for more than five years shall re-enter a licensed school, submit to a scholastic evaluation to determine their training needs, and complete a minimum of 150 hours of remedial education. Upon completion of the remediation, they may apply for and submit to the complete written theory examination, the applicable practical examination and a [~~fifty question~~] written state law examination.

B. Applicants whose license has expired for one year but less than five years shall submit to the applicable practical examination and a [~~fifty question~~] written state law examination.

C. Applicants who fail any portion of the examination must re-take that portion of the examination within one year of the date of failing the examination. In the event that the applicant does not re-examine within one year, he/she must re-enroll in a licensed school and repeat the applicable hours set forth in these rules in each of the failed subject areas in order to be eligible to re-take the examination for licensure.

[16.34.3.11 NMAC - Rp 16 NMAC 34.3.11, 06-16-01; A, 07-16-04]

NEW MEXICO BOARD OF BARBERS AND COSMETOLOGISTS

This is an amendment to 16.34.4 NMAC, Section 10, 12, and 14, effective July 16, 2004.

16.34.4.10 [~~**DEMONSTRATORS**~~

~~A. A demonstrator's license is required in order for a person to perform any of the services set forth in subsection L of 16.34.1.7 NMAC. The demonstrator's license may be renewed annually on March thirty first.~~

~~B. The demonstrator's license is NOT required for the purpose of guest speaking in a licensed school for the purpose of demonstrating products or techniques, providing theoretical instruction in specialized areas (e.g. first aid, salon management, etc.), or conducting motivational classes provided that a licensed Instructor is present and supervises the entire class.~~] [**RESERVED**]

[16.34.4.10 NMAC – Rp 16 NMAC 34.4.10, 06-16-01; Repealed, 07-16-04]

16.34.4.12 [~~**GUEST ARTISTS**~~

~~A. The Board allows a nonresident guest artist or technician to promote a product or technique in the State of New Mexico without a Demonstrator's license provided:~~

~~(1) the guest artist shall perform for educational or instructional purposes only and for no more than thirty days in any calendar year;~~

~~(2) the guest artist must hold a current license to practice, which need not be from New Mexico.~~

~~B. The privilege to perform as a guest artist shall not be used as a subterfuge to avoid instructor training or other licensing requirements.~~] [**RESERVED**]

[16.34.4.12 NMAC – Rp 16 NMAC 34.4.12, 06-16-01; Repealed, 07-16-04]

16.34.4.14 STUDENT PERMITS: Upon receipt of a complete student registration form and applicable fee, which shall be received in the board office within ten days of [~~enrollment~~] date of registration, the board will issue a student permit and permit number. The student permit authorizes the holder to practice course related skills in an approved school and perform services on the public only after fifteen percent of the required hours for graduation from the course of study are accrued. Student permits are the property of the board and must be returned to the board office with the notice of termination or official transcript of credit by the school. Additional requirements applicable to student permits are found in subsection A, paragraph 7 of 16.34.8.13 NMAC of these rules.

[16.34.4.14 NMAC - Rp 16 NMAC 34.4.14, 06-16-01; A, 07-16-04]

NEW MEXICO BOARD OF BARBERS AND COSMETOLOGISTS

This is an amendment to 16.34.5 NMAC, Section 8, effective July 16, 2004.

16.34.5.8 GENERAL LICENSURE REQUIREMENTS

A. Any person is eligible to be registered as a practitioner and is qualified to receive a license as a registered barber, cosmetologist, manicurist, esthetician, manicurist/esthetician, or electrologist who submits proof that he/she:

(1) is at least seventeen years of age;

(2) has an education equivalent to the completion of the second year of high school;

(3) has completed the course of study for the license in a licensed school [~~of barbering or cosmetology~~] within the preceding twenty-four months;

(4) has paid the required fees as set forth in these rules; and

(5) has passed the practical and written examination conducted by the board.

B. Any person is eligible for initial registration or re-registration as an instructor and is qualified to receive a license as an instructor who submits proof that he/she has met all the above requirements and in addition:

(1) has an education equivalent to the completion of FOUR years of high school; and

(2) holds a current license in New Mexico as a practitioner in the field in which the applicant is seeking licensure as an instructor.

C. Applicants who have not completed a course of study equivalent to the license for which he/she is applying may submit notarized letters of employment or employment records to prove licensed, current, verified work experience. Six full months of work experience will equal one-hundred-fifty hours of training. Work experience less than six full months will not be considered toward training hours.

[16.34.5.8 NMAC - Rp 16 NMAC 34.5.8, 06-16-01; A, 07-16-04]

NEW MEXICO BOARD OF BARBERS AND COSMETOLOGISTS

This is an amendment to 16.34.7 NMAC, Section 9, effective July 16, 2004.

16.34.7.9 SANITARY AND SAFETY RULES FOR ESTABLISHMENTS AND ENTERPRISES

A. All licensees who operate enterprise outreach mobile units or establishments must comply with the following minimum sanitation and safety standards. Failure to comply with these requirements may result in an administrative fine as provided in 16.34.15 NMAC of these rules and other disciplinary action by the board.

(1) maintenance of adequate ventilation to ensure that occupants are not improperly exposed to hazardous products or chemicals;

(2) maintenance of smoking restriction to ensure that products or chemicals used are not inadvertently ignited;

(3) maintenance of spill standards to ensure that occupants are not improperly exposed to any product or chemical;

(4) maintenance of hot and cold running water available in such quantities as necessary to perform professional services in a safe and sanitary manner while serving the public;

(5) maintenance of all equipment in safe working condition;

(6) maintenance of clean towels in enclosed containers or cabinets with appropriate sanitizing agents;

(7) maintenance of combs and brushes in enclosed containers or cabinets with appropriate sanitizing agents;

(8) compliance with local licensing, fire, building, health, ventilation, heating and safety requirements;

(9) every person engaged in a licensed enterprise or establishment must keep his/her person in a hygienic condition;

(10) all products and chemicals must be kept in labeled closed containers;

(11) there shall be adequate wet and dry sanitizers;

(12) floors, walls, and other fixtures must be kept reasonably clean at all times; cups, bowls, basins, jars and instruments must be sanitized prior to using on the public;

(13) rest rooms of establishments must be in working order and be segregated and have ceiling high partitions from the rest of the establishment or common area;

(14) [~~clean towels must be used on each client;~~] clean towels, sheets, robes and other linens must be used for each client; towels, sheets, robes, and other linens must be changed and properly laundered after each use; the use of paper or disposable towels, linens, etc. shall be in compliance with this rule and shall be disposed of after each use;

(15) [~~head rest must be sanitized after each use;~~] implementation of proper cleaning and sterilization of head rests, hand rests, pedicure basins, foot rests, manicure tables and other fixtures that come in contact with licensees and the public; filters and drains must be cleaned or changed according to manufacturer's instructions;

(16) implements must be sanitized in an appropriate germicidal solution by immersion according to the product manufacturer's direction;

(17) all licensees must provide a suitable place equipped to give adequate service, as advertised to clients, subject to inspection by the board;

(18) adherence to the product manufacturer's directions for safe use that appear on the product labeling;

(19) use of protective devices when so indicated by the product manufacturer's direction for safe use or when the nature of the product indicates such protection is necessary;

(20) implementation of proper hand washing practices to ensure that appropriate sanitary standards are maintained for clients and to ensure that cosmetology and barbering professionals are not overexposed to particular cosmetic products or their ingredients;

(21) implementation of proper storage practices to ensure that products are maintained in the manner that prevents any risk of fire or of undesired reactions;

(22) implementation of proper program of identification of products during use and in storage to avoid confusion as to products or their ingredients; such program shall include efforts to ensure that ingredient information provided by manufacturers or distributors remains available with the product for use by licensed professionals and clients;

(23) implementation of proper component mixing practices to reduce the risk of undesired reactions;

(24) implementation of proper sterilization practices of working tools and implements;

(25) licensees may not perform services on the public while under the influence of alcohol or drugs;

(26) maintenance of a material safety data sheet file containing pertinent facts regarding products; [~~and~~]

(27) the use, storage or dispensing of such beauty service products containing methyl methacrylate or other chemicals determined to be hazardous to the health of licensees or consumers by the board of any federal, state or local health agency, shall be prohibited; the identification of such materials shall be determined by proper testing procedures approved by the board;

(28) no establishment or school shall use any razor-edged device or tool for the purpose of removing skin or calluses; and

(29) all instruments and supplies that come in contact with a the public and cannot be disinfected (e.g. emery boards, sponges, cotton pads), shall be disposed of immediately after use.

B. Professional licensees who perform services in an outreach enterprise mobile unit must carry at all times a duplicate license which indicates that they have met the requirements stated in 16.34.4.15 NMAC of these rules.

[16.34.7.9 NMAC - Rp 16 NMAC 34.7.9, 06-16-01; A, 07-16-04]

NEW MEXICO BOARD OF BARBERS AND COSMETOLOGISTS

This is an amendment to 16.34.8 NMAC, Section 13 and 22, effective July 16, 2004.

16.34.8.13 REGULATIONS CONCERNING STUDENTS

A. Student registration

(1) When a school receives an application from a prospective student, it shall promptly notify the student of the registration requirements of the board.

(2) It shall constitute a violation of the rules, within the meaning of the act, for a school to engage in a pattern of failure to transmit student registration documents and fees in a timely fashion to the board pursuant to Subsection G of 16.34.15.8 NMAC, wherein fines will be imposed.

(3) It shall be the responsibility of the prospective student to comply with the registration requirements by the first day he/she attends class for credit. Failure to do so may result in loss of hours earned prior to proper registration.

(4) No school shall allow a student to attend class for credit until the student has complied with the registration requirements for age and secondary education as follows:

(a) Applicants for the barber, cosmetology, manicure/pedicure, esthetician, electrologist, and manicure/esthetician courses must be at least sixteen years of age and have successfully completed two years of high school or the equivalent.

(b) Applicants for the instructor course must be at least seventeen years of age and have successfully completed four years of high school or the equivalent.

(5) Acceptable proof of age and education requirements as follows:

(a) Proof of age includes a copy of a birth certificate, a driver's license or a state issued identification card, or a baptismal certificate.

(b) Proof of two years of secondary education includes a high school diploma, a G. E. D. certificate or transcript of G. E. D. test scores, a sealed letter from the high school attended, a copy of the high school transcript showing all required

grades have been passed, a letter from the G. E. D. testing facility stating that the G. E. D. test has been passed, or any other test approved by the United States department of education for the purpose of determining an applicant's ability to benefit, providing that documentation of GRADE EQUIVALENCY is established by the test publisher and the required grade level for the course of study has been achieved.

(c) The board, or its executive director, may accept as proof of secondary education the applicant's notarized statement that he/she has completed the required secondary education, but has been unable to obtain documentary proof of that from a FOREIGN NATION. A notarized statement will not be accepted for students who have completed the secondary education in the United States.

(6) Evidence of compliance with the foregoing requirements shall accompany the application for registration form provided by the board.

(7) Upon receipt of [~~the~~] a complete student registration form and applicable fee, which shall be [~~postmarked no later than ten working days after the student first attends class for credit and~~] received in the board office within ten days of [~~enrollment~~] the date of registration, the board office will then issue a STUDENT PERMIT and a permit number. The student permit authorizes the holder to practice course related skills in an approved school on the public only after successful completion of fifteen percent of the program. In addition, the student permit also authorizes the student to participate in the student externship program pursuant to 16.34.8.17 NMAC of these rules. A photograph of the student (front view, head only, at least 1.5" by 1.5") shall be attached to the permit. The permit shall be displayed in a binder in the school in which the student is enrolled and open to review by the state inspector or other board designee. Student permits are the property of the board and must be returned to the board by the school upon termination of the student's enrollment.

(8) If inspection of the student permits and school records determines that students are attending class without being properly registered with the board, the student may be denied the hours previously accrued and the school will be reported to the board for disciplinary action.

B. Student transfers/re-entries

(1) Any previously registered student desiring to transfer to another school, or re-enter the previous school shall submit a new registration form and required fees to the board. Students transferring schools as a result of a school closure shall submit a new registration form but are not required to pay a re-registration fee. Students attending a school, which undergoes a change of ownership, are not required to re-register with the board.

(2) Any student desiring to re-enter school after the board's record retention requirement has expired must submit a sealed transcript for the successfully completed previous training in order to receive credit for it.

(3) A student enrolled in any course may withdraw and transfer hours or equivalent credit acquired to another course not to exceed the amount of hours or equivalent credit of each subject within the new course curriculum requirements. Appropriate termination notices and course registration documents must be submitted to the board office when a student transfers to another course.

(4) Students enrolled in the cosmetology curriculum may take the examination for one of the specialty courses at which time the school certifies that the student has completed the requirements for the course in which the student seeks licensure. All other requirements for examination must also be met. The student may continue to attend classes in the cosmetology course. However, if licensure is obtained in any specialty course and the student continues attending classes in the cosmetology course, he/she cannot perform any services on the public in the school for which the individual is now licensed.

C. Records of student academic progress

(1) Schools shall keep records of academic progress for each student and these records shall be open for inspection by members of the board or its designees. The inspector will review lesson plans, student test grades, and practical skills grades for students to ensure that curriculum requirements are being met prior to course completion.

(2) Schools will designate in the enrollment contract and other consumer information, all requirements for withdrawal or graduation. When all requirements have been met, the school must return the student's permit to the board, and submit a sealed official transcript of training to the board and to the student showing that course requirements for graduation have been met. The board recognizes for transfer, hours or equivalent credits reported on the official transcript of training. Circumstances regarding transfer of or approval of student hours may be brought to the board on an individual basis for special consideration by the board. The board may, in its discretion, recognize hours or equivalent credit or partial hours or partial credit for transfer when an official transcript of training has not been submitted by the school.

(3) If a student terminates his/her enrollment status without meeting all withdrawal or graduation requirements, the school in which he/she was enrolled shall notify the board of termination in writing within thirty days of the student's formal termination date using the format prescribed by the board, and return the student's permit.

(4) Schools offering clock hour training may define its attendance requirements to include one hundred percent attendance for the course length or may allow excused absences for no more than twenty five percent of the course length for satisfactory course completion; schools are advised, however, that pursuant to Section 668.164(b), the U. S. department of education allows only up to ten percent excused absences for federal title IV recipients.

(a) student attendance policies are applied uniformly and fairly.

(b) attendance policies give appropriate credit for all hours attended;

(c) do not add or deduct attendance hours as a penalty;

(d) the school shall report actual hours attended by the student OR shall round the hours to the nearest half hour (i.e. if a student attended forty-four minutes past the hour, the school would report the previous half hour; if a student attended forty-five minutes past the hour, the school would report the next hour);

(e) the school must maintain attendance records for each student to verify that the minimum attendance standard set forth by the board is being met;

(f) in cases where schools are authorized to offer training via distance learning methods, the school establish standards for converting competencies achieved to clock or credit hours.

(5) To be considered a graduate, a student must have completed the course scheduled for completion and met the minimum attendance standard (or seventy five percent) of the established course of study and all other academic and evaluation factors established by the school. Therefore, in addition to completion of the required hours, the student must have satisfactorily completed the practical and theoretical curriculum requirements set forth by the school. Those requirements must include documentation that the student has satisfactorily completed each unit of study prescribed by the board in the applicable course of study. The excused absences DO NOT allow a student to accelerate in their course of study. Even though they may limit excused absences, they WILL NOT be allowed to sit for the state licensing examination until the number of hours prescribed by the board for the applicable course of

study have elapsed.

(6) If a student is required OR allowed by the school to train more than the scheduled hours in a class day, he/she must be given credit for the additional time in the appropriate subject. Students may choose to attend more than the scheduled hours in any one day to accelerate completion of the course ONLY under supervised instruction approved and authorized by the school. Schools have full discretion in setting forth class schedules for each course offered as long as minimum requirements for graduation meet the board standards.

(7) Students may not be called from a scheduled theory class to perform services on the public.

(8) Schools expressing academic measurement in terms of credit hours shall set forth requirements for each unit of study within a course or program which ensure that required levels of competency or skills ability have been met. Such schools must award appropriate credit for each unit of study completed satisfactorily. Records of the students' academic progress within the course of study must be maintained for all students.

(9) The school shall provide a catalog to prospective students containing enough information to permit an informed choice among training opportunities and institutions. Catalogs which comply with the school's accrediting agency will be deemed to comply with this rule.

(10) Schools must comply with the Family Education Right to Privacy Act and must guarantee the rights of students and their parents or guardians, if the student is a dependent minor, to have access to their cumulative records and provide for proper supervision and interpretation of student records when reviewed.

(11) Schools and students shall enter into a signed written agreement which fully and accurately reflects the contractual rights and obligations of the parties, particularly with regard to suspension, expulsion, refunds, tuition and fees, withdrawal and graduation requirements. Contracts which comply with the school's accrediting agency will be deemed in compliance with this rule.

D. Records regarding state board examinations: Each school shall disclose to prospective students its annual statistics regarding the school's state examination pass rate. The board will send a letter to each school after each examination containing the result information on each student, which will serve as the source documentation for calculating the disclosed statistics.

[16.34.8.13 NMAC - Rp 16 NMAC 34.8.13, 06-16-01; A, 07-16-04]

16.34.8.22 DISTANCE EDUCATION: It is recognized that delivery of relevant course content can be achieved in a variety of methods including online learning and distance education. Programs such as Instructor training may be completely accomplished via distance learning. Practitioner programs are limited to no more than twenty-five percent of the program content online. The following standards should apply when schools choose to use distance learning methods.

A. The school must notify the board and obtain approval before offering any distance learning courses.

B. The school must determine if the student has the requisite skills and competencies to succeed in a distance learning environment prior to enrollment.

C. The school must make available to students the necessary textbooks, supplementary educational materials and equipment needed to fulfill the program requirements.

D. The school must establish measurable and achievable performance outcomes that shall be compared to similar subject matter and objectives whether offered through traditional or distance methods.

E. The school must specify the expected knowledge, skills, and competency levels that students will achieve in a distance learning course.

F. The school shall effectively oversee the distance learning course and ensure it meets the objectives and mission of the school.

G. The school is responsible for the quality of courses of study offered through distance learning and the achievement of expected acceptable outcomes for each student irrespective of any contractual arrangements, partnerships, or consortia entered into with third parties for provision of components of a distance learning course.

[16.34.8.22 NMAC - N, 07-16-04]

NEW MEXICO BOARD OF BARBERS AND COSMETOLOGISTS

This is an amendment to 16.34.9 NMAC, Section 10, effective July 16, 2004.

16.34.9.10 ADVANCED TRAINING: Educational programs provided for the purpose of continuing or advanced education in a specific field of licensure that are more than one hundred fifty hours in length must be conducted in a licensed school and supervised by a licensed instructor whether or not the program leads to licensure. Programs for advanced or continuing education of one hundred fifty hours or less will be considered seminars or workshops. They may or may not be conducted in a licensed establishment but must be supervised by a New Mexico licensee [~~or Guest Artist~~] or approved provider for continuing education.

[16.34.9.10 NMAC - Rp 16 NMAC 34.9.10, 06-16-01; A, 07-16-04]

NEW MEXICO BOARD OF BARBERS AND COSMETOLOGISTS

This is an amendment to 16.34.11 NMAC, Section 8, effective July 16, 2004.

16.34.11.8 VIOLATIONS BY LICENSEES

A. When the board becomes aware of information or evidence tending to indicate that a violation of the act or these rules has been or is being committed by a licensee or student, it will review the matter and take appropriate action, or it may refer the matter to an informal subcommittee for review and recommendation, or it may make such investigation as it deems appropriate.

B. If an investigation is made, upon conclusion, the board shall:

(1) take no further action; or

(2) [~~seeks issuance by the Office of the Attorney General of a Notice of Contemplated Action under the Uniform Licensing Act;~~] issue a notice of contemplated action (NCA) under the Uniform Licensing Act;

(3) invite the parties to an informal conference with the board or the board's designee to aid in the board's resolution of the matter;

(4) assess an administrative penalty pursuant to 16.34.15 NMAC of these rules, subject to appropriate procedural requirements and safeguards;

(5) file a formal complaint with the magistrate court;

(6) issue or direct the board's executive director to issue a letter of warning, a statement of what the board believes must be done to come into compliance with the act or these rules or a similar communication.

[16.34.11.8 NMAC - Rp 16 NMAC 34.11.8, 06-16-01; A, 07-16-04]

NEW MEXICO BOARD OF BARBERS AND COSMETOLOGISTS

This is an amendment to 16.34.13 NMAC, Section 10, effective July 16, 2004.

16.34.13.10 EXAMINATION PROCEDURES

A. To be eligible for examination, the applicant must meet all of the following requirements:

(1) be at least seventeen years of age;

(2) have at least two years of high school or its equivalent;

(3) complete the required hours or equivalent credits of training in the specific course of study in a licensed school [~~of cosmetology, barbering or electrology~~] within the preceding twenty-four months;

(4) submit an exam application to the board office; and

(5) submit a money order or cashier's check in the appropriate amount to the board office with the application; do not send personal checks or cash.

B. What to bring to the cosmetology examination:

(1) the bulletin of information;

(2) kit containing required supplies listed in the bulletin of information;

(3) photo identification (e.g. driver's license); and

(4) one live model or mannequin head; a mannequin maybe used for the hair-shaping portion only of the exam, when a live model is used;

(5) if mannequin is used, must bring one mannequin hand with sculptured nails already applied.

C. What to bring to the barbering examination:

(1) the bulletin of information;

(2) kit containing required supplies listed in the bulletin of information;

(3) photo identification (e.g. driver's license); and

(4) two live models or mannequin heads; a mannequin maybe used for the hair-shaping portion only of the exam, when live models are used.

D. What to bring to the manicuring/pedicuring examination:

(1) the bulletin of information;

(2) kit containing required supplies listed in the bulletin of information;

(3) photo identification (e.g. driver's license); and

(4) one live model or two mannequin hands, one with sculptured nails already applied and one without sculptured nails; the applicant cannot bring a live model and a mannequin hand, its either or.

E. What to bring to the esthetician examination:

(1) the bulletin of information;

(2) kit containing required supplies listed in the bulletin of information;

(3) photo identification (e.g. driver's license); and

(4) one live model.

F. What to bring to the manicuring/esthetician examination:

(1) the bulletin of information;

(2) kit containing required supplies listed in the bulletin of information;

(3) photo identification (e.g. driver's license);

(4) one live model for the esthetician practical; and

(5) one live model or two mannequin hands, one with sculptured nails already applied and one without sculptured nails, for the manicuring practical.

G. Instructor eligibility requirements:

(1) be at least seventeen years of age;

(2) have at least a four-year high school course or its equivalent;

(3) complete the required hours or equivalent credits of training in a licensed school within the preceding twenty-four months or two years work experience in the field that you seek licensure; work experience is to be verified in a notarized statement by an employer, including specific work dates;

(4) submit an exam application to the board office;

(5) be licensed in the state of New Mexico as a practitioner in the field that you seek licensure as an instructor;

(6) meet all requirements established by the board; and

(7) submit a money order or cashier's check in the appropriate amount with the application; personal checks or cash are not accepted.

H. What to bring to the instructor examination:

(1) the bulletin of information;

(2) photo identification (e.g., driver's license).

I. Special needs: If an applicant has a physical disability or a special need that prevents him/her from taking the examination under the regular conditions, he/she may request special accommodations. Written documentation of the disability must be submitted to the board office to determine what special accommodations are necessary. If special accommodations are needed to take the exam, the board office must be notified with the examination application.

J. Policy on cheating: The exchange of information related to exam performance between examinees during the exam is prohibited. Examinees are not allowed to have any written or taped material in the testing area other than the supplies listed and approved for the exam.

[16.34.13.10 NMAC - Rp 16 NMAC 34.13.10, 06-16-01; A, 07-16-04]

NEW MEXICO BOARD OF BARBERS AND COSMETOLOGISTS

This is an amendment to 16.34.14 NMAC, Section 8, effective July 16, 2004.

16.34.14.8 FEES: The fees for examination, original licensure and annual renewal, licensure by reciprocity and special fees are as follows:

A.	Enterprise or establishment license (original).....	[~~$100.00~~] $125.00
B.	Enterprise or establishment license (renewal).....	[~~$ 35.00~~] $ 45.00
C.	Booth establishment license (original).....	[~~$100.00~~] $125.00
D.	Booth establishment license (renewal).....	[~~$ 35.00~~] $ 45.00
E.	School license (original and renewal).....	[~~$350.00~~] $435.00
F.	Relocation of a school.....	[~~$150.00~~] $185.00
G.	Barber license (original and renewal).....	[~~$ 20.00~~] $ 25.00
H.	Cosmetologist license (original and renewal).....	[~~$ 20.00~~] $ 25.00
I.	Manicurist/pedicurist license (original and renewal).....	[~~$ 20.00~~] $ 25.00
J.	Manicurist/esthetician license (original and renewal).....	[~~$ 20.00~~] $ 25.00
K.	Electrologist license (original and renewal).....	[~~$ 20.00~~] $ 25.00
L.	Esthetician license (original and renewal).....	[~~$ 20.00~~] $ 25.00
M.	Instructor license (original and renewal).....	[~~$ 20.00~~] $ 25.00
N.	Reciprocity (original).....	[~~$100.00~~] $125.00
O.	Temporary practitioner license.....	[~~$ 10.00~~] $ 15.00

[~~P.~~	~~Demonstrator's License (original and renewal)~~	~~$ 50.00~~]
[~~Q.~~]P.	Administrative fee (lists)	[~~$ 50.00~~] $ 65.00
[~~R.~~]Q.	Administrative fee (lists on disks)	[~~$ 75.00~~] $ 95.00
[~~S.~~]R.	Administrative fee (relocation of establishments, etc.)	[~~$ 20.00~~] $ 25.00
[~~T.~~]S.	Lists on address labels (list fee plus actual cost of labels)	
[~~U.~~]T.	Transcript fee	[~~$ 10.00~~] $ 15.00
[~~V.~~]U.	Examinations and re-examinations all licenses except instructor	[~~$ 35.00~~] $ 45.00
[~~W.~~]V.	Instructor examination and re-examination	[~~$ 35.00~~] $ 45.00
[~~X~~]W.	Duplicate licenses	[~~$ 10.00~~] $ 15.00
[~~Y.~~]X.	Student registration - any course	$ 15.00
[~~Z.~~]Y.	Identification license	[~~$ 20.00~~] $ 25.00
[~~AA.~~]Z.	Late fee	[~~$ 25.00~~] $ 35.00
[~~BB.~~]AA.	Provider approval, initial and renewal	[~~$ 20.00~~] $ 50.00

[16.34.14.8 NMAC - Rp 16 NMAC 34.14.8, 06-16-01; A, 07-16-04]

NEW MEXICO CHILDREN, YOUTH AND FAMILIES DEPARTMENT

PROTECTIVE SERVICES DIVISION

NOTICE OF REPEAL OF OBSOLETE POLICIES

Children, Youth and Families Department, Protective Services (PS) is repealing the following obsolete policies, effective June 30, 2004: CYFD ICD Rule 1, CYFD-OTS-1, HSSD 74-12, HSSD 74-19, HSSD 75-1, HSSD 75-3, HSSD 75-8, HSSD 77-8, SSD 12.0, SSD 100.0000, SSD 270.0000, SSD 405.0000, SSD B12.0.0, SSD 11.3.0, SSD 432.0000, SSD 434.0000, SSD 450.0000, SSD 461.0000, SSD 84-1, SSD 86.2, SSD 86-1, SSD 231.0, SSD 232.0, SSD 233.0, SSD 234.0, SSD 235.0, SSD 236.0, SSD 6.2.0, SSD 6.3.0, SSD 11.0.0, SSD B12.1.0, SSD B12.2.0, SSD B12.3.0, SSD 13.0.0, SSD 14.0.0, SSD A13.0.0, SSD B13.0.0, SSD C13.0.0, SSD D13.0.0, SSD E13.0.0, SSD F13.0.0, SSD G13.0.0.

NEW MEXICO ENERGY, MINERALS AND NATURAL RESOURCES DEPARTMENT

OIL CONSERVATION DIVISION

19 NMAC 15.M, Reports, filed 01-18-96, has been reformatted and renumbered to 19.15.13 NMAC to comply with the current NMAC requirements, effective 06/30/04.

NEW MEXICO ENERGY, MINERALS AND NATURAL RESOURCES DEPARTMENT

STATE PARKS DIVISION

This is an amendment to 19.5.2 NMAC, Sections, 10, 13, 16, 17, 23, 24, 27, and 28, effective 6/30/04

19.5.2.10 HOURS: The opening and closing times for every area and facility of the state parks system are established by the director or director designee. Hours are posted at the established park entrances, offices or pay stations.

[7-17-67, 12-31-96; A, 12-31-98; 19.5.2.10 NMAC - Rn, 19 NMAC 5.2.10, 12/31/02; A, 6/30/04]

19.5.2.13 USE OF FACILITIES:

A. All facilities are available on a first come, first serve basis with the exception of parks where a reservation program is established and the facility has been reserved. Campers shall not save or reserve camping spaces for other individuals even by purchasing additional permits. Campers shall not have sole and continuing possession of any picnic or shade shelter or other park facility to the exclusion of other park visitors except as provided in Sections 11 and 12 of this part unless special permission has been granted by the superintendent.

B. Persons using any park facility shall keep it in a clean and sanitary manner and shall leave it in a clean and sanitary condition.

C. Special facilities have been developed and designated for the use of individuals with disabilities. Individuals with disabilities shall have preferential use of these facilities over other persons.

D. Removing water for domestic use from the park or depositing domestic trash generated outside the park or from lease lots within a park is prohibited.

E. Advance reservations are required for the use of meeting rooms. Meeting rooms are not available at all parks. Any person who reserves a meeting room is responsible for setting up the room, cleaning the room after use and leaving the room in the same condition it was in before use. See 19.5.6 NMAC for meeting room fees.

F. The director may designate areas within the state parks system for use by reservation.

G. Advance reservations are required for the use of group shelters, group areas or reservation camp sites. All users are required to pay the appropriate day use or camping fees in addition to the reservation fee. Annual permits may [~~not~~] be accepted at [~~certain~~]reservation campsites as posted. See 19.5.6 NMAC for group shelter fees.

[7-17-67, 5-6-87, 12-31-96, 12-31-98; 19.5.2.13 NMAC - Rn & A, 19 NMAC 5.2.13, 12/31/02; A, 6/30/04]

19.5.2.16 OFF-HIGHWAY MOTOR VEHICLES: Operation of off-highway motor vehicles is prohibited except for off-highway vehicles the division uses for operation and maintenance.

A. [Reserved].

B. [Repealed].

C. [Repealed].

[7-25-72, 12-21-89, 12-31-96, 12-31-98; 19.5.2.16 NMAC - Rn, 19 NMAC 5.2.16, 12/31/02, A, 6/30/04]

19.5.2.17 SWIMMING: All swimming shall be at the swimmer's own risk. Swimming is prohibited within 150 feet of public or concession boat docks, launching ramps, [~~dams,~~] above or below dams, or where otherwise posted. Persons using air mattresses, inner tubes, surfboards, sail or wind, styrofoam flotation devices and other similar articles shall wear a U.S. coast guard approved personal flotation device or a flotation assist device.

[7-17-67, 12-31-96; 19.5.2.17 NMAC Rn & A, 19 NMAC 5.2.17, 12/31/02; A, 6/30/04]

19.5.2.23 CONDUCT:

A. Park visitors and campers are encouraged to enjoy all park experiences without infringing upon the ability of other visitors to enjoy the same experiences. Threatening, abusive, boisterous, insulting or indecent language and behavior are prohibited. Solicitation, gambling and illegal discrimination in any manner are prohibited.

B. Park visitors and campers shall not evade, disobey or resist any lawful order of a state park official.

C. Parents, guardians or

other adults in charge are required to exercise constant direct supervision of minor children or adults who do not possess the intelligence or awareness to recognize possible danger.

D. [~~A state park official may eject from a state park~~] [~~a~~]Any person who violates a state law or a regulation of the department or any person who evades, disobeys or resists any lawful order of a state park official may be forcibly ejected from a state park by law enforcement officers. Based on the severity of conduct or reported incident, i.e., threatening or intimidating conduct toward park visitors or park staff, the ejection may be permanent. Permanent ejection requires [~~an order by the superintendent or his designee~~] a written notification by the superintendent. To request review of a permanent ejection issued by the superintendent, an individual ejected from state parks shall submit a written request to the director within 15 days of issuance and provide written notice to the superintendent. A request shall include the reasons for requesting review. The superintendent and the ejected individual shall submit written statements to the director within 10 working days of the submission of the request for review. The director shall base his decision on the written statements unless the ejected individual or the superintendent requests the opportunity to call witnesses or make oral arguments within 10 working days of the request for review. A request for hearing shall explain the need for any witness testimony or oral argument. If the ejected individual or superintendent asks to make oral arguments or call witnesses, the director may set a hearing to be held within 10 working days of receiving that request and provide notice of the hearing date, time, and location to the superintendent and the ejected individual. Oral testimony shall be made under oath. A tape or stenographic record shall be made of any oral argument or witness testimony. The director shall issue a written final decision, including findings of fact within 10 working days after the date for submission of written statements, or a hearing if any, and send copies to the ejected individual and the superintendent.

[7-17-67, 5-6-87, 12-21-89, 12-31-96; 19.5.2.23 NMAC - Rn & A, 19 NMAC 5.2.23, 12/31/02; A, 6/30/04]

19.5.2.24 PETS:

A. Persons with dogs, cats or other domestic pets in areas of the state parks system shall be responsible for control of their pets, so as not to cause a nuisance to others. Pet owners shall ensure all pets are vaccinated in accordance with all applicable county ordinances and state laws.

B. Pet owners shall pick up after their pets and shall maintain the area in a clean and sanitary condition.

C. Owners shall restrain pets on leashes that are not more than 10 feet in length, except in areas designated by the superintendent. This rule shall not apply to pets being used in authorized activities such as field trials, retriever training or hunting.

D. Owners shall be required to prevent their pets from excessive barking, howling and loud noises, so as not to disturb others. Owners shall be required to prevent their pets from biting or attacking any person or destroying any property. Pets shall not be left unattended in vehicles or camp sites.

E. Pets are prohibited, except disability assistance dogs, with valid document that verifies the dog is an assistance dog that can be presented to the state park official at time of use, within all visitor centers and at the following parks:

(1) Rio grande nature center state park;

(2) Living desert state park; and

(3) Smokey Bear historical park.

[7-17-67 , 5-6-87, 12-21-89, 12-31-96, 12-31-98; 19.5.2.24 NMAC - Rn & A, 19 NMAC 5.2.24, 12/31/02; A, 6/30/04]

19.5.2.27 FEES AND CHARGES:

A. [~~All persons shall pay required fees, as described in 19.5.6 NMAC, upon entrance to a park.~~] Upon entering a state park, all fees and charges shall be paid in accordance with 19.5.6 NMAC. The visitor shall display applicable permits in accordance with instructions provided with the permit. Failure to obtain a permit shall result in field collection of fees and may include an administrative fee in addition to the required fee. See 19.5.6 NMAC. Failure to pay the administrative fee may result in civil damages, [~~a~~] criminal action, [~~and/or~~] or eviction from the park.

B. Permits shall be displayed at all times inside any park. Nonstop highway travel through a park on numbered state highways shall not require a park use permit.

C. The superintendent may waive or reduce park fees for organized youth groups, special events, government agencies or employees of businesses working with the division or its contractors. The director may waive or reduce fees for special circumstances.

D. A state park official may issue rain checks for unused, prepaid daily camping activities or the cancellation of a group shelter reservation.

E. Fees in addition to the appropriate use fee may be charged for reservation processing and cancellation. The reservation fee shall be collected for those park sites where a reservation program has been established. See 19.5.6 NMAC. The reservation fee shall be paid in advance with all applicable fees for camping, electricity or other service for the total period of the reservation.

F. Repealed.

[5-6-87, 12-21-89, 12-31-96, 12-31-98; 19.5.2.27 NMAC - Rn & A, 19 NMAC 5.2.27, 12/31/02; A, 6/30/04]

19.5.2.28 PERMITS AND PASSES:

A. Annual Permits:

(1) Annual day-use permits: authorize the vehicle owner or individual to access and use the park at no charge during the times indicated in Section 11 of this part. Annual day-use permits are available for use at all parks, except at the [~~rio grande nature center and~~] living desert state park and Smokey Bear historical park.

(2) Annual overnight camping permits: authorize the vehicle owner or individual to access and use the park at no additional charge except for utility hookups during the times indicated in Section 12 of this part.

(3) Veteran's permit: authorize a New Mexico resident veteran with a permanent one hundred percent service connected disability to obtain one non-transferable annual day-use permit at no charge for personal use only. An eligible veteran desiring more than one permit shall purchase additional annual day-use permits at full price. To obtain a permit, an eligible veteran shall present to the division the following proof of disability and New Mexico residency:

(a) a photocopy of the award letter issued by the United States department of veterans affairs indicating the veteran has a one hundred percent service connected disability; and,

(b) proof of New Mexico residency, such as a New Mexico driver's license, or other state of New Mexico-issued identification.

(4) Terms and Limitations:

(a) all permits expire on December 31 of the year issued, regardless of the date issued. No refund nor proration shall be made for permits that remain in effect for less than a full calendar year;

[~~**(b)** annual overnight camping permits are [only] available for:~~

~~**(i)** New Mexico residents [62 years of age or older with acceptable identification indicating the date of birth;~~

~~**(ii)** New Mexico residents [with disabilities with acceptable identification documenting disability;~~

~~**(iii)** New Mexico resi-~~

~~dency is documented with a current New Mexico driver's license or other state of New Mexico issued identification.~~]

(b) annual overnight camping permits are available for:

(i) New Mexico residents as documented with a current New Mexico driver's license or other state of New Mexico issued photo identification.

(ii) New Mexico residents 62 years of age or older as documented with a current New Mexico driver's license or other state of New Mexico issued photo identification;

(iii) New Mexico residents with disabilities as documented shall present a New Mexico handicap motor vehicle license plate or a blue handicap placard with a placard holder identification card issued by the New Mexico motor vehicle division containing their name and placard number to verify disability;

(iv) all-out-of-state-residents including senior citizens and persons with disabilities as described in Subsection D of 19.5.6.11 NMAC.

(c) Permits are not accepted at concession operated [~~camping grounds or other areas as described in Subsection G of 19.5.2.12 NMAC.~~] camp grounds.

(d) Replacement permits and stickers may be obtained by submitting the original permit, proof of purchase or issuance in the case of a veteran's permit, or signed affidavit describing the facts of the purchase or issuance, and loss or destruction of the permit. Effective January 1, 2006 the division shall no longer replace the annual day-use permit.

B. Leaseholders and Concessionaires: The director or [~~his/her~~] director designee (see Subsection N of 19.5.7 NMAC) may issue a park pass to leaseholders, concessionaires, concession permittees, or their commercial contractors, suppliers and agents, for the purpose of access to and from the concession or a lease lot. Leaseholders, concessionaires, concession permittees, or their commercial contractors, suppliers and agents using the park, lake or facilities away from the concession premises or lease lot are subject to the appropriate fees.

C. Contractors: The director or [~~his/her~~] director designee (see Subsection N of 19.5.1.7 NMAC) may issue a park pass to contractors, suppliers or agents of the division or other persons providing services to a park for the purpose of access to the park.

D. Complimentary Park Passes: The director or [~~his/her~~] director designee (see Subsection N of 19.5.1.7 NMAC) may issue complimentary passes to legislators, park advisory board members, volunteers or individuals who significantly contribute to the division or in exchange for promotion of the division or advertising.

E. Gift Certificates: The division may sell gift certificates for annual day use permits and annual camping permits.

F. Special Use Permits:

(1) Short term events and activities within the state parks system, such as regattas, boat races, parades, races, fishing tournaments, exhibitions and educational activities, are authorized only by a special use permit and only after payment of associated fees. See 19.5.6 NMAC. Special use permits shall only be issued for events and activities that provide a needed service to the park and that benefit the park. Applications for special use permits shall be submitted to the park where the event is proposed at least two weeks prior to the event, or at least 30 days prior to the event if the event is a regatta, motorboat or boat race, marine parade, tournament or exhibition. A special use permit shall not be issued for a period of more than five consecutive days. The park may charge fees in addition to the [~~minimum~~] special use fee to cover costs of additional staff, facilities, etc. needed for the event.

(2) Special Use Restrictions: No person shall violate any condition or restriction attached to or indicated on the special use permit. Violation of this regulation may result in the immediate cancellation of the permit.

[7-17-67, 12-21-89, 12-31-96, 12-31-98, 7-1-99; 19.5.2.28 NMAC - Rn & A, 19 NMAC 5.2.28, 12/31/02; A, 6/30/04]

NEW MEXICO ENERGY, MINERALS AND NATURAL RESOURCES DEPARTMENT

STATE PARKS DIVISION

This is an amendment to 19.5.6 NMAC Section 16 and 17, effective 6/30/04

19.5.6.16 CONCESSION PERMIT:

[~~$300.00~~]

A. Guide, fishing services, boating and rafting excursions for Navajo lake state park $ 500.00

B. For all other state parks, guide, fishing services, boating and rafting excursions $ 300.00

C. Educational and park resource protections services $ 300.00

[19.5.6.16 NMAC - Rp, 19 NMAC 5.6.16, 5/1/04; A, 6/30/04]

19.5.6.17 GUIDE CARD:

[~~$300.00~~]

A. Guide, fishing services, boating and rafting excursions for Navajo lake state park $ 500.00

B. For all other state parks guide, fishing services, boating and rafting excursions $ 300.00

[19.5.6.17 NMAC - Rp, 19 NMAC 5.6.17; 5/1/04; A, 6/30/04]

NEW MEXICO GENERAL SERVICES DEPARTMENT

RISK MANAGEMENT DIVISION

TITLE 1 GENERAL GOVERNMENT ADMINISTRATION
CHAPTER 6 RISK MANAGEMENT
PART 5 CERTIFICATES OF COVERAGE

1.6.5.1 ISSUING AGENCY:..General Services Department, Risk Management Division.
[1.6.5.1 NMAC - N, 7/1/2004]

1.6.5.2 SCOPE: This rule applies to state agencies and local public bodies for which the general services department, risk management division provides public liability fund coverage for risk or liability pursuant to NMSA 1978, Section 41-4-20 (A) (2) of the state of New Mexico Tort Claims Act [NMSA 1978, Section 41-4-1 et seq. (1976)] (hereinafter referred to as the "Tort Claims Act" or "the act")].
[1.6.5.2 NMAC - N, 7/1/2004]

1.6.5.3 STATUTORY AUTHORITY: This rule is statutorily authorized and promulgated pursuant to NMSA 1978, Section 15-7-3 (A) (7) (which authorizes the risk management division to issue certificates of coverage in accordance with the rulemaking procedures contained in NMSA 1978, Section 9-17-5 (E), granting the secretary of the general services department the general power to make and adopt such reasonable administrative and procedural rules and regulations as may be necessary to carry out the duties of the department and its divisions, including the risk management division). In addition, Section 41-4-23 (D) of the Tort Claims Act authorizes the general services department, risk management division to regulate claims made against the public liability fund. Pursuant to NMSA 1978, Section 15-7-2 (A), the director is responsible for the acquisition and administration of all insurance purchased by the state. Except as provided by NMSA 1978, Section 15-7-2, no state agency may procure any kind of insurance other than through the risk management division. Pursuant to NMSA 1978, Section 41-4-20 (C), no liability insurance

may be purchased by any governmental entity other than as authorized by the Tort Claims Act.
[1.6.5.3 NMAC - N, 7/1/2004]

1.6.5.4 DURATION: Permanent.
[1.6.5.4 NMAC - N, 7/1/2004]

1.6.5.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[1.6.5.5 NMAC - N, 7/1/2004]

1.6.5.6 OBJECTIVE: It is the public policy of the state of New Mexico that governmental entities and public employees shall be protected by the principle of sovereign immunity and may only be liable for torts as provided by the express provisions of the Tort Claims Act. The general services department, risk management division is authorized to issue certificates of coverage to governmental entities to defend the state of New Mexico in cases involving tort liability. This rule sets the parameters and procedures by which certificates of coverage are issued and amended by the director.
[1.6.5.6 NMAC - N, 7/1/2004]

1.6.5.7 DEFINITIONS: As used herein:

A. "coverage" or "coverage provision" means the type of protection provided against specific risks or losses;

B. "covered entity" means a governmental entity, as defined below, which is covered under the terms of a coverage document issued to it by the public liability fund through the general services department, risk management division;

C. "director" means the general services department, risk management division director;

D. "fund" or "the fund" means the public liability fund as defined in NMSA 1978, Section 41-4-23 of the Tort Claims Act;

E. "governmental entity" means the state and a local public body as defined in NMSA 1978, Section 41-4-3 (B), (C) and (H) in the act;

F. "public employee" means individuals as defined in NMSA 1978, Section 41-4-3 (F) of the act; and

G. "scope of duty" means the performance of duties as defined in NMSA 1978, Section 41-4-3 (G) of the act.
[1.6.5.7 NMAC - N, 7/1/2004]

1.6.5.8 ISSUANCE OF CERTIFICATES OF COVERAGE: Certificates of coverage shall be issued on an annual basis, unless otherwise determined by the director, on or before July 1 of the state fiscal year, and in the sole discretion of the director shall be in force on July 1 of that fiscal year, or as soon as practicable thereafter, and shall remain in effect for a period of one year from the date of issuance or until superceded by another certificate of coverage, unless otherwise earlier terminated in writing by the director. The director shall issue certificates of coverage by a letter of administration issued to a governmental entity attaching the certificates of coverage. The letter of administration will describe the type, extent, nature and description of coverage(s), and may also include other matters and administrative procedures reasonably necessary and which must be followed to carry on or administer the requirements of the Tort Claims Act.
[1.6.5.8 NMAC - N, 7/1/2004]

1.6.5.9 CERTIFICATE OF COVERAGE GUIDELINES: The following guidelines govern all certificates of coverage that may be issued under cover of a letter of administration.

A. By statute, NMSA 1978, Section 59A-1-16 (C), the general services department, risk management division is expressly exempt for the provisions of the insurance code of the state of New Mexico, NMSA 1978, Section 59A-1-1 et seq. Certificates of coverage do not provide insurance, but instead provide an understanding among the govnermental entitites of the state of New Mexico about the intent of the use of funds from the public liability fund. The public liability fund is a self-insurance mechanism established to handle losses to or claims against covered governmental entities. Although coverage through the fund may be in formats like or similar to insurance policies, the relationship between the fund and covered entities is not that of insurer and insured. No special duties, rules of construction, or other legal doctrines recognized by the courts or created by statute with respect to the relationship of an insurer to its insured shall apply to the fund or entities covered by it.

B. Pursuant to NMSA 1978, Section 41-4-23 (D), all decisions to expend money from the fund to provide coverage to defend, save harmless, and indemnify any state agency or employee of a state agency or a local public body or an employee of such local public body are within the discretion of the director.

C. Duty to Defend.

(1) Pursuant to NMSA 1978, Section 41-4-23 (B) (3), the general services department, risk management division may expend money from the public liability fund to defend, save harmless, and indemnify a governmental entity or employee of a governmental entity. This defense extends only as far as a governmental entity's duty to provide a defense pursuant to NMSA 1978, Section 41-4-20 (A) for causes of action that may be properly brought under the Tort Claims Act, and any defense provided by the general services department, risk management division for any legal claim or liability exposure is controlled by the terms of the valid and current certificate of coverage in force at the time the claim arose, to the limits of such certificate of coverage. The director may contract with one or more attorneys or law firms, or with the attorney general, to defend tort liability claims against governmental entities and their employees acting within the scope of their duties.

(2) Pursuant to NMSA 1978, Section 41-4-4 (G) of the Tort Claims Act, the general services department, risk management division's duty to defend continues after public employment with the governmental entity has been terminated if the occurrence for which damages are sought happened while the public employee was acting within the scope of duty while the public employee was in the employ of the governmental entity.

(3) Pursuant to NMSA 1978, Section 41-4-17 (B), any settlement or judgment in any action brought under the act constitutes a complete bar to any further legal action on the same occurrence against a governmental entity or public employee whose negligence gave rise to the action. As a result of any settlement or judgment in any action brought under the act, the duty to defend is deemed to have been satisfied by the general services department, risk management division, and no further duty to defend continues to exist.

D. Other than the following specified causes of action that have been waived under the Tort Claims Act, no other causes of action can be defended by the general services department, risk management division. Pursuant to the Tort Claims Act, a defense shall be provided for claims brought on the following grounds:

(1) pursuant to NMSA 1978, Section 41-4-5 of the Tort Claims Act, liability for damages resulting from bodily injury, wrongful death, or property damage caused by the negligence of public employees while acting within the scope of their duties in the operation or maintenance of any motor vehicle, aircraft or watercraft;

(2) pursuant to NMSA 1978, Section 41-4-6 of the act, liability for damages resulting from bodily injury, wrongful death, or property damage caused by the negligence of public employees while acting within the scope of their duties in the operation or maintenance of any building, public park, machinery, equipment, or furnishings; provided, however, that nothing in this subparagraph shall be construed as

granting waiver of immunity for any damages arising out of the operation or maintenance of works used for diversion or storage of water;

(3) pursuant to NMSA 1978, Section 41-4-7 of the act, liability for damages resulting from bodily injury, wrongful death, or property damage caused by the negligence of public employees while acting within the scope of their duties in the operation of airports; provided, however, that nothing in this subparagraph shall include liability for damages due to the existence of any condition arising out of compliance with any federal or state law or regulation governing the use and operation of airports;

(4) pursuant to NMSA 1978, Section 41-4-8 of the act, liability for damages resulting from bodily injury, wrongful death, or property damage caused by the negligence of public employees while acting within the scope of their duties in the operation of the following public utilities and services: gas, electricity, water, solid or liquid waste collection or disposal, heating, and ground transportation; provided, however, that nothing in this subparagraph shall include liability for damages resulting from bodily injury, wrongful death, or property damage caused by a failure to provide an adequate supply of gas, water, electricity, or services or arising out of the discharge, dispersal, release or escape of smoke, vapors, soot, fumes, acids, alkalis, toxic chemicals, liquids or gases, waste materials or other irritants, contaminants or pollutants into or upon land, the atmosphere or any watercourse or body of water;

(5) pursuant to NMSA 1978, Section 41-4-9 of the act, liability for damages resulting from bodily injury, wrongful death, or property damage caused by the negligence of public employees while acting within the scope of their duties in the operation of any hospital, infirmary, mental institution, clinic, dispensary, medical care home, or like facilities;

(6) pursuant to NMSA 1978, Section 41-4-10 of the act, liability for damages resulting from bodily injury, wrongful death, or property damage caused by the negligence of public employees licensed by the state or permitted by law to provide health care services while acting within the scope of their duties of providing health care services;

(7) pursuant to NMSA 1978, Section 41-4-11 of the act, liability for damages resulting from bodily injury, wrongful death, or property damage caused by the negligence of public employees while acting within the scope of their duties during the construction, and in subsequent maintenance of any bridge, culvert, highway, roadway, street, alley, sidewalk, or parking area; provided, however, that nothing in this subparagraph shall include liability for damages caused by a defect in plan or design of any bridge, culvert, highway, roadway, street, alley, sidewalk, or parking area; the failure to construct or reconstruct any bridge, culvert, highway, roadway, street, alley, sidewalk, or parking area; or a deviation from standard geometric design practices for any bridge, culvert, highway, roadway, street, alley, sidewalk, or parking area allowed on a case-by-case basis for appropriate cultural, ecological, economic, environmental, right-of-way through Indian lands, historical, or technical reasons, provided the deviation is required by extraordinary circumstances, has been approved by the governing authority; and is reasonable and necessary as determined by the application of sound engineering principles taking into consideration the appropriate cultural, ecological, economic, environmental, right-of-way through Indian lands, historical, or technical circumstances;

(8) pursuant to NMSA 1978, Section 41-4-12 of the act, liability for personal injury, bodily injury, wrongful death, or property damage resulting from assault, battery, false imprisonment, false arrest, malicious prosecution, abuse of process, libel, slander, defamation of character, violation of property rights or deprivation of any rights, privileges, or immunities secured by the constitution and laws of the United States or New Mexico when caused by law enforcement officers while acting within the scope of their duties;

(9) pursuant to NMSA 1978, Section 41-4-4 (B) (2) of the act, when alleged to have been committed by a public employee while acting within the scope of their duties, liability for any violation of property rights or any rights, privileges or immunities secured by the constitution and laws of the United States or the constitution and laws of New Mexico.

E. Pursuant to NMSA 1978, Section 41-4-4 (D) of the act, and whether it is a governmental entity or the general services department, risk management division that provides a defense, the governmental entity shall pay any settlement or any final judgment entered against a public employee for any tort that was committed by the public employee while acting within the scope of their duty, or a violation of property rights or any rights, privileges, or immunities secured by the constitution and laws of the United States or the constitution and laws of New Mexico that occurred while the public empoyee was acting within the scope of their duty.

F. Pursuant to NMSA 1978, Section 41-4-4 (H) of the act, the duty of the governmental entity to pay any settlement or any final judgment entered against a public employee as provided in this section shall continue after employment with the governmental entity has terminated if the occurrence for which liability has been imposed happened while the public employee was acting within the scope of his duty while in the employ of the governmental entity.

G. All actions for damages brought against a governmental entity shall be subject to the maximum liability limits contained in NMSA 1978, Section 41-4-19.

H. Pursuant to NMSA 1978, Section 41-4-28, coverage which may be provided for liability arising under and subject to the substantive law of a jurisdiction other than New Mexico, including but not limited to other states, territories, and possessions and the United States, is not limited by the maximum liability limits contained in NMSA 1978, Section 41-4-19, and such coverage may be provided pursuant to the provisions of NMSA 1978, Section 41-4-28 (B).

[1.6.5.9 NMAC - N, 7/1/2004]

1.6.5.10 COVERAGE, APPORTIONMENT, AND UNDERWRITING STANDARDS: Specific risks covered, properties covered, coverage limits, exclusions, apportionment of contributions, underwriting standards, and other provisions for coverage through the public liability fund shall apply in accordance with certificates of coverage, letters of administration, or other coverage documents issued by the director to each covered entity. Pursuant to NMSA 1978, Section 15-7-2 (B), the director shall apportion contributions toward the purchase of insurance or for the providing of coverage for any risk not insured and the amount of contributions to be made by each governmental entity in a letter of administration issued to the governmental entity. Pursuant to NMSA 1978, Section 15-7-3 (A) (3), the director may prescribe underwriting standards for governmental entities in a letter of administration issued to the governmental entity.

[1.6.5.10 NMAC - N, 7/1/2004]

1.6.5.11 COVERAGE DISPUTES:

A. The director shall make a determination if the certificate applies to a presented claim. The decision of the director may only be appealed through arbitration, and such arbitration shall be requested by the covered party in writing to the director within 30 days of receipt of the written decision of the director.

B. If arbitration is requested, the covered entity and the director, on behalf of the fund shall, select one arbitrator within 15 days and submit the arbitrator's name in writing to the other side. Within 10

days after the selection of the two arbitrators, those two arbitrators shall select a third independent arbitrator. If the two sides cannot agree on the selection of the third arbitrator within those 10 days, either side may petition the First Judicial District Court in the county of Santa Fe for the appointment of the third arbitrator. The third arbitrator shall be an attorney and preside as the Chairperson of the arbitration panel. No arbitrator shall be employed or affiliated with the covered entity or the general services department, risk management division.

C. A decision of the panel shall be reported in writing to the director and to the covered entity. The written decision of the panel shall be given to both sides within thirty days of the close of the hearing.

D. All decisions of the arbitration panel shall be final and binding upon the parties and shall not be subject to any further appeal or court action.
[1.6.5.11 NMAC - N, 7/1/2004]

1.6.5.12 PREMIUM ESTABLISHMENT: The director shall determine the appropriate premiums for coverage provided to each covered entity, on an annual basis and in the sole discretion of the director, and shall be reported to each covered entity in a letter of administration from the director. In making the premium determination, the director may use, among other actuarially sound factors, information regarding a covered entity's use of risk control standards and a covered entity's compliance with underwriting standards, such standards being established by the director.
[1.6.5.12 NMAC - N, 7/1/2004]

HISTORY of 1.6.5 NMAC: [RESERVED]

NEW MEXICO DEPARTMENT OF HEALTH
PUBLIC HEALTH DIVISION

7.30.2 NMAC, Title X Family Planning Services, filed August 8, 2001, is hereby repealed, effective June 30, 2004.

NEW MEXICO HUMAN SERVICES DEPARTMENT
INCOME SUPPORT DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 100 RECIPIENT POLICIES - DEFINITIONS AND ACRONYMS

8.106.100.1 ISSUING AGENCY: New Mexico Human Services Department.
[8.106.100.1 NMAC - N, 07/01/2004]

8.106.100.2 SCOPE: The rule applies to the general public.
[8.106.100.2 NMAC - N, 07/01/2004]

8.106.100.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.
[8.106.100.3 NMAC - N, 07/01/2004]

8.106.100.4 DURATION: Permanent.
[8.106.100.4 NMAC - N, 07/01/2004]

8.106.100.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.106.100.5 NMAC - N, 07/01/2004]

8.106.100.6 OBJECTIVE:

A. The objective of general assistance is to provide cash assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched cash assistance program, such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low-income individual at the time of death.
[8.106.100.6 NMAC - N, 07/01/2004]

8.106.100.7 DEFINITIONS

A. Definitions A-L:

(1) Adult residential shelter care home: means a shelter care home for adults that is licensed pursuant to the regulations established by the department of health.

(2) Application: means a written request for assistance, on the appropriate ISD form, signed by or on behalf of an individual or family.

(3) Attendant: means an individual needed in the home for medical, housekeeping or child care reasons.

(4) Authorized representative: means an adult who is designated in writing by the applicant and is sufficiently knowledgeable about the applicant/benefit group's circumstances to complete the application form correctly and represent the benefit group.

(5) Basic needs: means food, clothing, shelter, utilities, personal requirements and the individual's share of household supplies.

(6) Beginning month: means the first month or the initial month for which a benefit group is certified after a lapse in certification of at least one calendar month in any project area; a benefit group is budgeted prospectively in a beginning month.

(7) Benefit group: means an individual or group of individuals authorized to receive cash assistance financed by state or local funds.

(8) Benefit month: means the month for which cash assistance benefits have been issued.

(9) Budget month: means the calendar month for which income and other circumstances of the benefit group shall be determined in order to calculate the cash assistance amount.

(10) Capital gains: means the proceeds from the sale of capital goods or equipment.

(11) Cash assistance: means state-funded cash assistance in the general assistance program, the adult residential home care shelter program, or the burial assistance program for the indigent.

(12) Certification: means the authorization of eligibility of a benefit group for the issuance of cash assistance benefits.

(13) Certification period: means the time period in calendar months that is assigned to a benefit group that is

approved to receive cash assistance benefits.

(14) Collateral contact: means an individual or agency designated to provide information concerning eligibility.

(15) Date of entry/admission: means the date established by the immigration and naturalization service as the date an alien (or sponsored alien) was admitted for permanent residence.

(16) Department: means the human services department.

(17) Dependent child: means an individual who is seventeen years of age or younger; eighteen years of age and enrolled in high school; or between eighteen and twenty-two years of age and is receiving special education services regulated by the state public education department.

(18) Director: means the director of the income support division.

(19) Disability: means the definitions of disability related to the general assistance program and the disability determination process found at 8.106.420.7 NMAC.

(20) Documentation: means a written statement entered in the case record regarding the type of verification submitted and a summary of the information obtained to determine eligibility.

(21) Earned income: means cash or payment in-kind that is received as wages from employment or payment in lieu of wages; and earnings from self-employment or earnings acquired from the direct provision of services, goods or property, production of goods, management of property or supervision of services.

(22) Emancipated: means an individual under the age of 18 who is legally recognized as no longer under parental control due to the individual's marriage or by a decision of a court.

(23) Encumbrance: means debt owed on property.

(24) Equity value: means the fair market value of property, less any encumbrances owed on the property.

(25) Expedited services: means the process by which a household reporting little or no income or resources will be provided an opportunity to participate in the food stamp program by the seventh day after an application is filed.

(26) Fair hearing: means an administrative proceeding which a claimant and/or his representative may request if:

(a) an application is not acted on within a reasonable time after the filing of the application;

(b) an application is denied in whole or in part; or

(c) cash assistance or services are modified, terminated or not provided.

(27) Fair market value (FMV): means the amount an item can be expected to sell for on the open market at the prevailing rate of return. For vehicles, the term FMV means the amount a dealer would buy a vehicle for wholesale or as a trade-in, not the amount the dealer would sell the vehicle for at retail.

(28) Federal act: means the federal Social Security Act and rules promulgated pursuant to the Social Security Act.

(29) Federal fiscal year: means the time period beginning on October 1 and ending on September 30 of the calendar year.

(30) Federal poverty guidelines: means the level of income defining poverty by family size, published annually in the federal register by the United States department of health and human services.

(31) Food Stamp Act: means the federal Food Stamp Act of 1977 (P.L. 95-113) and subsequent amendments enacting the food stamp program.

(32) Government entity: means any federal, state, tribal or local unit of government as well as any non-government entity that receives public funds for the purpose of meeting the needs of its clientele.

(33) Gross income: means the total amount of earned or unearned income before any voluntary or involuntary deductions are made, such as, but not limited to, federal and state taxes, FICA, garnishments, insurance premiums (including medicare), and monies due and owing the benefit group but diverted by the provider. Gross income does not include specific income exclusions, such as but not limited to, the cost of producing self-employment income and income excluded by federal law.

(34) Gross income test: means the income test applied to the maximum income eligibility limit for participation in a particular cash assistance program based on the size of the household or benefit group.

(35) Head of household: means an individual who is the responsible case head for the benefit group. The head of household may be the parent, guardian, sole adult member, specified relative, pregnant woman, a recipient of general assistance, or caretaker.

(36) Initial month: means the first month for which a benefit group is certified for participation in the cash assistance program. An initial month is also a month in which a benefit group is certified following a break in participation of one calendar month or longer.

(37) Inquiry: means a request for information about eligibility requirements for a financial, medical, or food assistance program that is not an application for that program.

(38) Institution of higher education: means any education institution which normally requires a high school diploma or equivalency certificate for enrollment, including, but not limited to, colleges, universities, and vocational or technical schools at the post-high school level.

(39) Institution of post-secondary education: means an institution of post-secondary education, any public or private educational institution that normally requires a high school diploma or equivalency certificate for enrollment, or that admits persons who are beyond the age of compulsory school attendance in the state in which the institution is located, regardless of the high school prerequisite, provided that the institution is legally authorized by the state to provide an educational program beyond secondary education or a training program to prepare students for gainful employment.

(40) Irrevocable trust funds: means an arrangement to have monies held by one person for the benefit of another that cannot be revoked.

(41) Issuance month: means the calendar month in which cash assistance is issued.

B. Definitions M-Z:

(1) Medicaid: means medical assistance under title XIX of the Social Security Act, as amended.

(2) Minor unmarried parent: Means an unmarried parent who is under the age of 18 years or is age 18 and enrolled in high school.

(3) Month of approval: means the month in which the action is taken to approve a benefit group for cash assistance.

(4) Net income test: means the income test applied to eligibility for a particular program after all allowable deductions are taken from the gross income for the household or benefit group. To be eligible, the benefit group's net earned income must be less than the standard of need applicable to the benefit group after allowable deductions have been made to the earned and unearned income.

(5) Net monthly income: means gross non-exempt income minus the allowable deductions. Net monthly income is the figure used to determine eligibility and cash assistance benefit amount.

(6) New Mexico works: means the federally funded temporary cash assistance program for needy families that carries a sixty-month term limit for adults in the state.

(7) Non-benefit group members: means persons residing with a benefit group but who are specifically excluded by regulation from being included in the benefit group certification.

(8) Notice of adverse action (NOAA): means a written notice sent 13

days in advance of an action to reduce, suspend or terminate benefits that includes a statement of the action the department intends to take, the reason for the action, the benefit group's right to a fair hearing, who to contact for additional information, the availability of continued benefits, and liability of the benefit group for any overpayment received if the hearing decision is adverse to the benefit group.

(9) Overpayment/overissuance: means the amount by which cash assistance benefits issued to a benefit group exceed the amount the benefit group was eligible to receive.

(10) Parent: means a natural parent, adoptive parent, stepparent or legal guardian.

(11) Payment: means the amount of the cash assistance benefit, after the countable net earned and unearned income of the benefit group has been subtracted from the benefit group's standard of need, and before any reduction by sanction and/or recoupment.

(12) Person: means an individual.

(13) Project area: means the geographic area designated to a county office that is responsible for the administration of the department's programs.

(14) Prospective budgeting: means the computation of a benefit group's eligibility and benefit amount based on a reasonable estimate of income and circumstances that will exist in the current month and future months.

(15) Quarterly reporting: means a reporting requirement that allowed a twelve-month certification period and required a benefit group to submit a report form every third month during the certification period.

(16) Real property: means land, affixed improvements and structures, which include mobile homes. Grazing permits are also considered real property.

(17) Recertification: means a complete review of all conditions of eligibility and a redetermination of the amount of the cash assistance benefits for an additional period of time.

(18) Recipient: means a person receiving cash assistance benefits.

(19) Regular reporting: means a reporting requirement in which a benefit group is not required to meet periodic reporting requirements, and must report changes within ten days of the date the change becomes known.

(20) Resource standard: means the financial standard with respect to an applicant's/recipient's resources and property, which is set at $2,000 for non-liquid resources and $1500 for liquid resources.

(21) Retrospective budgeting: means the computation of a benefit group's benefits for an issuance month based on actual income and circumstances that existed in the previous month.

(22) Secretary: means the secretary of the human services department.

(23) Self-employed: means an individual who engages in a self-managed enterprise for the purpose of providing support and income.

(24) Semiannual reporting: means a requirement for a benefit group to file a report of information in the sixth month of a twelve-month certification period to determine if eligibility for benefits can continue.

(25) Shelter for battered women and children: means a public or private nonprofit residential facility that serves battered women and their children. If such a facility serves other individuals, a portion of the facility must be set aside on a long-term basis to serve only battered women and children.

(26) Single-parent benefit group: means a benefit group that does not include both parents of a child who is included in the benefit group and thus includes families in which there is only one parent or in which there are no parents.

(27) Standard of need: means a maximum cash benefit amount that is based on the number of individuals included in the benefit group and allows for a financial standard and basic needs.

(28) Supplemental security income (SSI): means monthly cash payments made under the authority of:

(a) Title XVI of the Social Security Act, as amended, to the aged, blind and disabled;

(b) Section 1616(a) of the Social Security Act; or

(c) Section 212(a) of P.L. 93-66.

(29) Two-parent benefit group: means a benefit group in which both parents of a child included in the benefit group live in the home with the child and are included in the benefit group.

(30) Term limit: means the 60-month lifetime limit under the TANF/NMW cash assistance program, which is applied to an adult or minor head of household and spouse of the minor head of household, for receipt of cash assistance benefits or support services funded by the TANF block grant.

(31) Unearned income: Means old age, survivors and disability insurance payments (social security); railroad retirement benefits; veterans administration compensation or pension payments; military retirement and allotments; pensions, annuities and retirement benefits; lodge or fraternal benefits; other public or private disability or retirement benefits or pension; shared shelter payments; individual Indian money (IIM); royalty or lease payments for land or property owned by a benefit group member; settlement payments resulting from insurance or litigation; worker's compensation benefits; child support; unemployment compensation benefits; union benefits paid in cash; gifts and contributions; and real property income.

(32) Verification: means the use of third-party information or documentation to establish the accuracy of statements on the application.

(33) Wage subsidy program: means a subsidized employment opportunity through which a TANF cash assistance recipient is hired into full-time employment.

[8.106.100.7 NMAC - N, 07/01/2004]

8.106.100.8 ABBREVIATIONS AND ACRONYMS

A. Abbreviations and acronyms:

(1) AFDC: aid to families with dependent children (replaced by TANF effective July 1, 1997)

(2) ARSCH: adult residential shelter care home

(3) BG: benefit group

(4) BIA: bureau of Indian affairs

(5) BIA-GA: bureau of Indian affairs-general assistance

(6) CA: cash assistance

(7) CE: categorical eligibility or categorically eligible

(8) CFR: code of federal regulations

(9) CS: child support

(10) CSED: (HSD) child support enforcement division

(11) CYFD: (New Mexico) children, youth & families department

(12) DOH: (New Mexico) department of health

(13) DOL: department of labor

(14) DOT: dictionary of occupational titles

(15) E&T: employment and training (food stamp work program)

(16) EBT: electronic benefit transfer

(17) EI: earned income

(18) EW: eligibility worker (now FAA)

(19) EWP: education works program

(20) FAP: financial assistance program

(21) FAA: family assistance analyst (formerly ISS)

(22) FFY: federal fiscal year

(23) FMV: fair market value

(24) FNS: food and nutrition service (formerly FCS)

(25) FPL: federal poverty level

(26) FSP: food stamp program
(27) GA: general assistance
(28) GED: general equivalency degree
(29) HHS: (U.S. dept. of) health and human services
(30) HSD: (New Mexico) human services department
(31) HUD: (U.S. dept. of) housing and urban development
(32) IDA: individual development account
(33) INS: (U.S.) immigration and naturalization service
(34) IPV: intentional program violation
(35) IRP: individual responsibility plan
(36) IRU: incapacity review unit
(37) ISD: (HSD) income support division
(38) ISD2: integrated services delivery for income support division (ISD)
(39) ISS: income support specialist (now FAA)
(40) JTPA: Job Training Partnership Act (now WIA)
(41) LIHEAP: low income home energy assistance program
(42) LITAP: low income telephone assistance program
(43) MAD: (HSD) medical assistance division
(44) MVD: (New Mexico) motor vehicle division
(45) NADA: national automobile dealers association
(46) NMAC: New Mexico administrative code
(47) NMW: New Mexico works
(48) NOAA: notice of adverse action
(49) POS: point of sale
(50) PED: (New Mexico) public education department
(51) QC: quality control
(52) QR: quarterly reporting
(53) RR: regular reporting
(54) RRP: refugee resettlement program
(55) SAVE: systematic alien verification for entitlements
(56) SE: self employment
(57) SR: semiannual reporting
(58) SSA: social security administration
(59) SSI: supplemental security income
(60) SSN: social security number
(61) TANF: temporary assistance to needy families (block grant program under title IV-A of the Social Security Act)
(62) UCB: unemployment compensation benefits
(63) UEI: unearned income
(64) USDA: United States department of agriculture
(65) VA: veterans administration
(66) WIA: Workforce Investment Act
(67) WID: work incentive deduction
(68) WPA: work participation agreement

B. Medical abbreviations and acronyms:
(1) CNP: certified nurse practitioner
(2) MD: medical doctor
(3) NP: nurse practitioner
(4) PA: physician assistant
(5) PN: practical nurse

[8.106.100.8 NMAC - N, 07/01/2004]

HISTORY OF 8.106.100 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
INCOME SUPPORT DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 110 GENERAL OPERATING POLICIES - APPLICATIONS

8.106.110.1 ISSUING AGENCY: New Mexico Human Services Department.
[8.106.110.1 NMAC - N, 07/01/2004]

8.106.110.2 SCOPE: The rule applies to the general public.
[8.106.110.2 NMAC - N, 07/01/2004]

8.106.110.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.
[8.106.110.3 NMAC - N, 07/01/2004]

8.106.110.4 DURATION: Permanent.
[8.106.110.4 NMAC - N, 07/01/2004]

8.106.110.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.106.110.5 NMAC - N, 07/01/2004]

8.106.110.6 OBJECTIVE:
A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program, such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low-income individual at the time of death.
[8.106.110.6 NMAC - N, 07/01/2004]

8.106.110.7 DEFINITIONS: [Reserved]
[8.106.110.7 NMAC - N, 07/01/2004]

8.106.110.8 GENERAL:
A. Project area: The application for cash assistance shall be made to the human services department in the project area in which the applicant resides. The project area is the geographic area designated to a county office that is responsible for the administration of the department's programs.

B. Application form: The application shall be in writing on a form designated by the department and shall be made under oath by an applicant or an applicant on behalf of a dependent child who resides in the home. The application must contain a statement of the age of the applicant and/or dependent child, residence in New Mexico, all property in which the applicant has an interest, the income of the applicant or other benefit group members at the time the application is filed; the signature of the applicant, and other information required by the department.

C. EBT issuance: Cash assistance benefits, when authorized, shall be available through an electronic benefit transfer (EBT) account.
[8.106.110.8 NMAC - N, 07/01/2004]

8.106.110.9 RIGHT TO APPLY:
A. An individual has the right to make a formal application for any cash, food or medical assistance program administered by the department, regardless of whether or not the individual appears to meet the conditions of eligibility.

(1) Any individual requesting information or assistance, or who wishes to apply for assistance, shall be encouraged to complete an application that same day.

(2) An individual shall be informed of the right to apply, whether or not it appears the individual will be found

eligible.

(3) An individual shall be informed that the date of application affects the benefit amount for the first month of issuance.

B. Availability of applications: Application forms for general assistance programs shall be readily available to anyone requesting an application, and to local agencies and organizations that have regular contact with the public. Each county office is responsible for providing program applications to local agencies and organizations. If an individual contacts the office by phone or mail and does not wish to come to the office to pick up an application, the individual shall be mailed an application on the same day the office is contacted.
[8.106.110.9 NMAC - N, 07/01/2004]

8.106.110.10 SUBMISSION OF THE APPLICATION FORM

A. Items completed: To be accepted and registered, the cash assistance application, at a minimum, must identify the individual or individuals applying, the program(s) applied for, and must contain the signature of a responsible benefit group member, caretaker or authorized representative.

B. Who completes the application: The application form must be completed by the applicant, the authorized representative, caretaker, guardian, or other responsible individual.

(1) An authorized representative must be:

(a) designated in writing by the applicant/head of household; and

(b) an adult who has sufficient knowledge of the applicant/benefit group's circumstances to complete the application form correctly.

(2) If an authorized representative or another appropriate individual completes an application form on behalf of an applicant, the actual applicant must review and approve the completed form. The applicant is liable for improper payments resulting from erroneous information given by the authorized representative or other appropriate individual.

(3) The caseworker may assist in completing the form if there is no other individual who can help the applicant.

(4) Application for minor children: An application for assistance for minor children, including an un-emancipated minor pregnant woman, must be made by the adult with whom the child or children reside and who is assuming responsibility for the support and care of the child or children.

(a) If a minor pregnant woman is living in a second-chance home, maternity home or other adult-supervised supportive living arrangement, the application must be made by the supervising adult as the authorized representative for the minor pregnant woman.

(b) An emancipated minor may file an application in the emancipated minor's own right.

C. Signature:

(1) The application form must be signed by the applicant and authorized representative if one is designated.

(2) If an applicant receives assistance from someone other than a caseworker in completing the application form, that individual who assists must also sign at the bottom of the application form.

(3) An individual who cannot sign his or her own name must sign the application with a mark and have it witnessed. A mark that is not witnessed shall not be accepted as a valid signature. A caseworker may not witness signatures on an application the caseworker will be processing.

(4) If the application is made on behalf of a child, the form shall be signed by the caretaker with whom the child is living, or by the authorized representative.

(5) If the individual, relative or caretaker has a legally-appointed guardian, the guardian must complete and sign the form.

D. Filing an application: An application may be filed in person, by mail or via facsimile with the ISD office in the project area serving the community or county where the applicant lives. If an applicant files the application in the wrong project area, the applicant shall be referred to the correct project area. If the applicant wishes to complete an application the same day, the project area shall accept the completed application, register it, and immediately transfer the form to the correct project area. If an application is mailed to the incorrect project area, that office shall register the application and immediately transfer the form to the correct project area.

E. Incomplete application: If an application is incomplete, ISD shall take prompt action to notify the applicant. The individual who completed the application form must add the missing or incorrect information and initial and date the entries. All reasonable action shall be taken by ISD to avoid any unnecessary delay of the applicant's eligibility determination.

F. Out-of-state applicants: An application mailed in from out of state shall be accepted, but shall not be registered until the applicant contacts ISD to confirm his or her presence in the state. If the applicant does not contact the ISD within 30 days from receipt of the application, the application shall be returned to the applicant.

G. Application registration: A signed in-state application shall be registered effective the date on which the application is received by the ISD office.
[8.106.110.10 NMAC - N, 07/01/2004]

8.106.110.11 INTERVIEWS

A. Application interview:

(1) All applicants shall be interviewed in person at the local office in the project area in which the applicant resides.

(2) When circumstances warrant, the interview may take place at another location reasonably accessible and agreeable to both the applicant and the caseworker.

(3) The applicant may bring any individual to the interview.

B. Office interview waivers: Waiver of the requirement that the interview be conducted in the ISD office shall be determined on a case-by-case basis for any individual who is unable to appoint an authorized representative, has no one able to accompany the applicant to the office because of transportation difficulties, or similar hardships that the county director determines warrants a waiver of the office interview. These hardship conditions include, but are not limited to: illness, care of benefit group member, prolonged severe weather, or work hours which prevent an in-office interview during work hours.

C. Alternatives to an office interview: If an office interview is waived, the caseworker shall conduct a telephone interview or a home visit. Home visits shall be scheduled in advance with the benefit group as provided for at 8.100.180.17 NMAC. Waiver of the office interview, in and of itself, shall not be justification for extending the eligibility determination deadlines.

D. Scheduling an interview: An interview shall be scheduled upon receipt of the application. The interview shall take place within ten working days of the date an application is filed and, to the extent possible, at a time that is convenient for the applicant.

E. Missed interview: An applicant who fails to appear for the first interview shall be responsible for scheduling a second appointment for an interview. If the applicant does not contact the office or does not appear for a rescheduled interview, the application shall be denied on the 60th day (or the next workday if the 60th day is not a workday) after the application was filed.

F. Purpose and scope of interview: The interview is an official and confidential discussion of benefit group circumstances between the applicant and the caseworker.

(1) Prior to processing an applica-

tion, there shall be a face-to-face interview with the applicant. The purpose and scope of the interview shall be explained to the applicant.

(2) The interview is intended to provide the applicant with information regarding eligibility requirements for the program and to provide the caseworker with the necessary information and documentation to make an accurate eligibility determination. In addition, the interview allows the caseworker to clarify unclear or incomplete information reported on the application.

(3) At initial application a brief history shall be required in the case narrative explaining the circumstances that led to the application. The narrative shall include information clearly describing the child's situation with respect to child support from a non-custodial parent or parents.

G. Applicant information: During the course of the interview all reasonable steps shall be taken to make the applicant feel at ease and protect the applicant's right to privacy. The interviewer shall inform the applicant about the following:

(1) the requirements that must be met by the applicant under the requested cash assistance program;

(2) responsibility to report changes;

(3) complaint and fair hearing procedures;

(4) application processing standards;

(5) procedures in cases of overpayment or underpayment of benefits;

(6) non-discrimination policies and procedures;

(7) timeliness standards.

[8.106.110.11 NMAC - N, 07/01/2004]

8.106.110.12 APPLICATION PROCESSING TIME LIMITS

A. Timeliness: The caseworker shall explain time limits and the applicant's right to request a fair hearing if the application is not processed within the applicable time limits.

B. Application processing time limit:

(1) An application for general assistance shall be processed no later than 60 days from the date the application is filed.

(2) An application for a supplemental payment from the ARSCH program shall be processed no later than 30 days from the date the application is filed.

(3) An application for payment of burial expenses for a deceased individual shall be processed no later than 30 days from the date the application is filed.

C. Tracking the application processing time limit: The application processing time limit begins on the day after the signed application is received in the ISD county office.

D. Delayed determination: If an eligibility determination is not made within the required application processing time limit, the applicant shall be notified in writing of the reason for the delay, and that the applicant has the right to request a fair hearing regarding ISD's failure to act within the time limits.

E. GA disability determination delayed: The application for GA for disabled adults shall remain in pending status until a disability determination is made either by the caseworker or by the incapacity review unit. The application shall be processed by the county office no later than three working days after the caseworker makes the disability determination or the county office receives notification of a disability determination from the incapacity review unit.

[8.106.110.12 NMAC - N, 07/01/2004]

8.106.110.13 DISPOSITION OF APPLICATION/NOTICE

A. Denials: If an application is denied, ISD shall issue a written notice to the applicant. The denial notice shall include the date of denial, reason for denial, the regulation citation under which the denial was made, the applicant's right to a fair hearing concerning the denial, and the time limits for filing a fair hearing request. The notice shall also explain that the applicant may discuss the denial with the caseworker, supervisor or county director.

B. Approvals: If the application is approved, the applicant shall be notified in writing. The notice shall report the first and last month of eligibility, amount of payment and the members who have been determined eligible.

C. Application withdrawal: An applicant may voluntarily withdraw the application orally or in writing any time before eligibility determination. A notice shall be sent to confirm the applicant's expressed desire to withdraw the application. Applicants shall be advised that withdrawal of the application does not affect the right to apply for assistance in the future.

[8.106.110.13 NMAC - N, 07/01/2004]

8.106.110.14 APPROVAL EFFECTIVE DATE: Beginning with applications dated July 1, 2004, or later, general assistance benefits for an approved application shall be effective as of the date of application. Payment in the first month shall be prorated from the date of application.

[8.106.110.14 NMAC - N, 07/01/2004]

8.106.110.15 CASE RECORD TRANSFERS: If a recipient moves to another county in New Mexico or to an area administered by another project area, the recipient's case record shall be transferred as follows:

A. Responsibilities of sending county:

(1) The project area to which the recipient is moving or has moved to shall be promptly notified. The record shall not be transferred to the new project area until a new address for the recipient is provided to the sending county office.

(2) Before transferring the case record, the sending county shall review the case record to ensure the information is complete and updated. The sending county shall enter the recipient's new address and the geographic and administrative county number in the computer system.

B. Responsibilities of receiving county:

(1) The case is reviewed for changes and continued eligibility at the time of the transfer.

(2) The receiving project area shall transfer in the case by contacting the recipient to update the circumstances of the case and, at a minimum, document the benefit group's current circumstances. The receiving project area shall act on any change that becomes known by the sending project area, the recipient or any other means.

C. Transfer pending approval of an application: If transfer of a benefit group's case record is necessary before eligibility has been determined on an application, the sending county shall transfer the pending application and associated documents to the receiving county. The receiving county shall continue the determination of eligibility based on the new circumstances. The application shall be completed based on the original application date.

[8.106.110.15 NMAC - N, 07/01/2004]

History of 8.106.110 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 120 ELIGIBILITY POLICY - CASE ADMINISTRATION

8.106.120.1 ISSUING AGENCY: New Mexico Human Services Department.

[8.106.120.1 NMAC - N, 07/01/2004]

8.106.120.2 SCOPE: The rule

applies to the general public.
[8.106.120.2 NMAC - N, 07/01/2004]

8.106.120.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.
[8.106.120.3 NMAC - N, 07/01/2004]

8.106.120.4 DURATION: Permanent.
[8.106.120.4 NMAC - N, 07/01/2004]

8.106.120.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.106.120.5 NMAC - N, 07/01/2004]

8.106.120.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally-matched financial assistance program, such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low income individual at the time of death.
[8.106.120.6 NMAC - N, 07/01/2004]

8.106.120.7 DEFINITIONS: [Reserved]
[8.106.120.7 NMAC - N, 07/01/2004]

8.106.120.8 CHANGE REPORTING REQUIREMENTS

A. Requirement to report changes: The individual designated as the head of household in the GA-disabled adult program or the adult caretaker of an unrelated dependent child, whether or not the caretaker is a benefit group member, must report certain changes affecting the benefit group.

B. Department responsibilities: The caseworker shall inform the benefit group of its responsibility to report changes. The caseworker shall be required to take action on any change reported by the benefit group to determine if the change affects eligibility or benefit amount. The caseworker shall document the date a change is reported and whether the change affects eligibility or benefit amount.

C. Benefit group responsibilities at application: An applicant must report all changes affecting eligibility and benefit amount that may have occurred since the date the application was filed and before the date of the interview. Changes occurring after the interview, but before the date of the approval notice, must be reported by the benefit group within ten (10) days of the date the change is known to the benefit group.

D. Change reporting requirements for active cases: A benefit group must report changes within ten (10) days of the date a change becomes known to the benefit group.

(1) A financial change becomes known to the benefit group when the benefit group receives the first payment attributed to an income or resource change, or when the first payment is made for an allowable expense.

(2) A nonfinancial change, including but not limited to a change in benefit group composition or a change in address, becomes known to the benefit group on the date the change takes place.

(3) A change is considered reported by the benefit group on the date the report of change is received by the local county office or, if mailed, the date of the postmark on the benefit group's report, plus three mailing days.

(4) In the absence of a written report, a 13-day notice of adverse action is required if the change will result in a reduction or termination of benefits.

E. GA time-limited disability: A recipient of GA based on a time-limited disability that is expected to last six months or less is not required to report any changes during the individual's certification period.

F. GA-disabled adults: A recipient of GA for disabled adults based on a temporary or permanent time period must report the following changes during the benefit group's certification period:

(1) an individual moves into or out of the place of residence of the benefit group;

(2) a recipient or other benefit group member leaves the state;

(3) a change in earned income, such as starting a job or losing a job, changing employers, a change from part-time to full-time employment status, or a change in wage rate or salary;

(4) a change in unearned income, such as losing income or gaining a source of unearned income;

(5) when the resources of the benefit group equal or exceed the resource limit for the GA program;

(6) assignment of a social security number to a benefit group member; and

(7) a move from one home to another, regardless of whether mail is being sent to the new address.

G. GA-dependent child program/caretaker included: The caretaker of an unrelated dependent child who is included in the GA benefit group, must report the following changes for the benefit group:

(1) an individual moves into or out of the place of residence of the benefit group;

(2) a recipient or other benefit group member leaves the state;

(3) a change in earned income, such as starting a job or losing a job, changing employers, a change from part-time to full-time employment status, or a change in wage rate or salary;

(4) a change in unearned income, such as losing income or gaining a source of unearned income;

(5) when the resources of the benefit group equal or exceed the resource limit for the GA program;

(6) when a dependent child, who is a member of the benefit group is not in compliance with school attendance requirements;

(7) information about the noncustodial parent of a dependent child who is a member of the benefit group, including the whereabouts, social security number, employer, or any other information that may assist with the location of the noncustodial parent;

(8) assignment of a social security number to a benefit group member; and

(9) a move from one home to another, regardless of whether mail is being sent to that address.

H. GA-dependent child program/caretaker not included: A caretaker who is not included in the GA benefit group must report the following changes for any unrelated child included in the benefit group:

(1) an individual moves into or out of the place of residence of the benefit group;

(2) a benefit group member leaves the state;

(3) a change in unearned income, such as losing income or gaining a source of unearned income;

(4) the resources of the benefit group equal or exceed the resource limit for the GA program;

(5) when a dependent child who is included in the benefit group is not in compliance with school attendance requirements;

(6) information about a noncustodial parent of a dependent child who is a

member of the benefit group, including the whereabouts, social security number, employer, or any other information that may assist with the location of the noncustodial parent;

(7) assignment of a social security number to a benefit group member; and

(8) a move from one home to another, regardless of whether mail is being sent to that address.

[8.106.120.8 NMAC - N, 07/01/2004]

8.106.120.9 CERTIFICATION PERIODS

A. Certification period: Cash assistance shall be approved for a fixed certification period at the end of which the assistance shall be terminated.

B. Assigning the certification period:

(1) GA-time-limited disability: The certification period for a individual with a verified time-limited disability shall be set for the length of the disability established by medical documentation, and shall be assigned for a fixed period beginning the month of application and not to exceed six months.

(2) GA-temporary disability: The certification period for a temporary disability depends on the type and length of disability established by medical documentation, and shall be assigned for a fixed period of six months, beginning the month of application. A temporary disability with a duration of six months or longer shall be reviewed and verified by the IRU prior to extending the certification period beyond six months.

(3) GA-permanent disability: The certification period for a permanent disability shall be twelve months, beginning in the month of application. A permanent disability with a duration of 12 months or longer shall be reviewed and verified by the IRU prior to extending the certification period beyond the first six months.

(4) GA-unrelated dependent child: The certification period begins in the month of application and cannot exceed six months.

(5) Shelter home care: Adults receiving a state supplement payment for SSI recipients in an ARCSH setting shall be certified for twelve months, beginning in the month of application.

[8.106.120.9 NMAC - N, 07/01/2004]

8.106.120.10 ELIGIBILITY REVIEWS

A. Follow-up reviews: A follow-up review shall be scheduled during a certification period whenever information becomes known to the county office indicating a possible change in a benefit group's circumstances that may affect eligibility or benefit amount.

B. A follow up review may be made by home visit, office visit, third party contacts or correspondence as needed.

C. Circumstances that may require follow-up review include, but are not limited to:

(1) the continued disability of an adult who received GA disability based on a recommendation of the physician or the IRU;

(2) compliance with a contingency requirement by an adult with a determined disability;

(3) school attendance of children age six or older who are benefit group members;

(4) any other anticipated or reported change in circumstances that may affect eligibility or benefit amount during a certification period.

D. A follow up review is not required for an individual who has been approved for GA based on a time-limited disability and the GA certification period is six months or less.

E. Disability: The need for a disability review during the certification period is based on a determination of the length of the disability by the incapacity review unit. A finding that an individual no longer meets the program definition of disability shall result in termination of benefits at any time during the certification period.

[8.106.120.10 NMAC - N, 07/01/2004]

8.106.120.11 DETERMINING CONTINUED ELIGIBILITY

A. Recertification of eligibility: The recertification shall consist of a complete review of all conditions of eligibility, a determination of eligibility for an additional period of time, and redetermination of the amount of cash assistance payment.

B. Interview: A face-to-face interview between the caseworker and the recipient or caretaker shall take place at the end of the certification period, unless the individual's physical or mental condition makes the interview impossible or inadvisable. The county director may waive the face-to-face interview on a case-by-case basis for hardship reasons found at 8.106.110.11 NMAC.

C. Financial eligibility: Financial eligibility must be reviewed at the end of the certification period for the specific program to determine continued eligibility for a new period of time.

D. Disability: A disability review may or may not be required at the end of the certification period. The need for a disability review is based on a determination of the length of the disability by the incapacity review unit.

E. Child support enforcement: The caseworker shall ensure that CSED has been notified of all pertinent information regarding the noncustodial parent(s) of any dependent child in the benefit group, including but not limited to the current address, social security number and work place of the noncustodial parent.

F. Conditions not subject to change: The caseworker shall review the documentation of conditions not subject to change. If the record does not contain satisfactory evidence, additional verification shall be obtained.

G. Other programs: The caseworker shall give information to the general assistance recipient about other assistance programs, such as the food stamp and medicaid programs.

H. Need and payment determination: The caseworker shall:

(1) obtain current information about benefit group income, resources and other circumstances that are required to make an accurate determination of continued eligibility for and amount of payment from the general assistance program; and

(2) make a prospective determination of eligibility beginning the month following the month the certification period expires.

I. Change reporting: The caseworker shall review with the recipient the possible changes in circumstances that must be reported and may affect the client's eligibility or benefit amount. The caseworker shall provide a change report form upon request, which the client may use to notify the county office of changes.

J. Exchange of information with the social security administration:

(1) If information received during an eligibility review or recertification indicates that a GA recipient may be eligible for supplemental security income (SSI) benefits, (including children and adults who appear disabled and needy adults over age 65), the caseworker shall promptly refer the recipient to the social security administration (SSA) district office for application. An individual found eligible for SSI must participate in that program instead of the GA program.

(2) During the review process, the caseworker may obtain information relevant to the eligibility of a family member who is an SSI recipient. If there is a clear indication that a SSI recipient's countable income exceeds the maximum allowable under the SSI program, that information shall be reported to the SSA district office. SSA shall also be notified when it appears that the resources of an SSI recipient exceed SSI program standards.

[8.106.120.11 NMAC - N, 07/01/2004]

8.106.120.12 HANDLING BENEFIT GROUP AND RESIDENCE STATUS CHANGES

A. Change of name or payee: Whenever there is a change in a recipient's name or in the payee's name for cash assistance, the caseworker shall immediately make the appropriate changes.

(1) New caretaker of an unrelated dependent child:

(a) If a new caretaker assumes responsibility for an unrelated dependent child in a case, the case shall be closed and a new application processed.

(b) If the new caretaker is already has an active cash assistance case for other dependent children, the cash assistance case for the children being transferred shall be closed, and the children added to the existing benefit group.

(2) Payee change after benefits are issued:

(a) Warrants: If there is a change of payee after warrants have already been mailed and the original payee is not available to endorse the warrant, the caseworker shall request that the warrant be returned to the county office to effect the change. The face of the original warrant shall be voided and the warrant sent to the administrative services division for HSD. A replacement warrant shall be issued in the name of the new payee.

(b) EBT: When cash assistance benefits have been posted to an EBT account, the EBT account can be accessed by another family member through authorization of a new PIN under the old account.

(3) Changes in name or payee are made when:

(a) a payee legally changes his or her name and the change has been processed through the social security administration;

(b) a legal guardian is appointed or dismissed;

(c) the parent of an incompetent adult recipient begins to serve as natural guardian; or

(d) there is a change of caretaker for an unrelated dependent child.

B. Change in benefit group composition: A request for assistance for a new benefit group member shall be treated as a change. Eligibility for the new benefit group member begins in the month following the month in which all eligibility factors for the individual have been met and verified.

C. Leaving the state: If a recipient advises the county office in advance of the recipient's departure from the state, the recipient shall be contacted to determine whether the recipient intends to be out of the state for a temporary period with a plan to return once the purpose of the visit has been accomplished or to abandon residence in New Mexico.

(1) The caseworker shall determine:

(a) whether the recipient is eligible to continue receiving assistance out-of-state during a temporary absence;

(b) whether the recipient intends to apply for assistance in another state;

(c) how long the recipient intends to be out-of-state;

(d) the purpose of the visit; and

(e) whether a place of residence in New Mexico is being maintained in the recipient's absence.

(2) If it appears that New Mexico residence is being abandoned, cash assistance shall be terminated. If the absence is temporary, cash assistance shall be continued and the recipient must keep the department informed of his or her address and circumstances.

D. Illness: If a recipient who is temporarily visiting outside New Mexico is unable to return to New Mexico due to illness, cash assistance may continue until such time as the recipient is able to return. The recipient's inability to return to New Mexico due to illness must be verified by a physician's report.

E. DVR training out-of-state: If plans are made in conjunction with DVR for a recipient's participation in a training course in another state, cash assistance may be continued for the duration of the training course provided that the recipient or benefit group intends to return to New Mexico when the training is completed.

[8.106.120.12 NMAC - N, 07/01/2004]

History of 8.106.120 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 230 GENERAL FINANCIAL - PAYABLES AND DISBURSEMENT

8.106.230.1 ISSUING AGENCY: New Mexico Human Services Department.
[8.106.230.1 NMAC - N, 07/01/2004]

8.106.230.2 SCOPE: The rule applies to the general public.
[8.106.230.2 NMAC - N, 07/01/2004]

8.106.230.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.
[8.106.230.3 NMAC - N, 07/01/2004]

8.106.230.4 DURATION: Permanent.
[8.106.230.4 NMAC - N, 07/01/2004]

8.106.230.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.106.230.5 NMAC - N, 07/01/2004]

8.106.230.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low income individual at the time of death.
[8.106.230.6 NMAC - N, 07/01/2004]

8.106.230.7 DEFINITIONS: [Reserved]
[8.106.230.7 NMAC - N, 07/01/2004]

8.106.230.8 WARRANTS

A. EBT issuance of benefits: The department issues cash assistance benefits through an electronic benefit transfer (EBT) system. In very rare circumstances a cash assistance payment will be issued by warrant.

B. Replacements of a written warrant:

(1) The term "lost, stolen or forged warrant" shall be applied to any cash assistance warrant that was not received by the recipient or payee or was lost after receipt but before endorsement by the recipient or payee. A lost or stolen warrant may be replaced if:

(a) it has not been endorsed by the recipient or payee; and

(b) its loss or theft is reported within 45 days of the date of issuance.

(2) The 45-day limit may be waived by the income support division if

the recipient or payee was unable to report the loss or theft within the required time limit because of circumstances beyond his or her control. The director of the income support division shall make the determination regarding the waiver of the time limit.

(3) Replacement procedures:

(a) If a recipient or payee reports the non-receipt or loss of a warrant, the caseworker shall first ascertain whether the warrant was issued from the central office. If the warrant has not been issued, it shall be necessary to determine the reason why it was not, have the warrant issued, and notify the recipient or payee.

(b) If the warrant was mailed but not received by the recipient, or was received but lost or stolen before the recipient could negotiate it, the recipient must complete a claim for lost, stolen, or forged warrant.

(c) Upon receiving the report of a lost warrant, payment on the original warrant shall be stopped.

(d) As a part of the signing the lost warrant form, it shall be explained to the recipient that the original warrant must be returned to the department if it is received after the report is filed, as the original warrant will no longer be valid.

(4) Negotiated warrants: If the original warrant has been negotiated after a report of lost warrant is filed, the office of inspector general shall investigate whether the warrant was forged or negotiated by the payee.

(a) If the warrant is found to have been negotiated by the payee, no replacement shall be issued and the county office shall be notified.

(b) If the warrant was forged, the warrant shall be returned to the bank as refused, and a replacement warrant shall be issued.

C. Receipt of warrant reported as lost or stolen: If the recipient receives the original warrant after filing a lost warrant report, and notifies the caseworker as agreed on the claim form, the caseworker shall void the original warrant and return it to the human services department accounting section for disposition.

[8.106.230.8 NMAC - N, 07/01/2004]

8.106.230.9 DEATH OF A RECIPIENT

A. Payment: Payment may be made on behalf of a recipient who died before a warrant was endorsed or cashed or before an EBT withdrawal was made if:

(1) the recipient was alive on the first day of the month for which cash assistance benefits were issued; and

(2) he or she met all eligibility conditions at the time of death.

B. Authorized beneficiary: The only individual who is authorized to use the deceased recipient's benefits is:

(1) the surviving spouse of a disabled adult; or

(2) the caretaker of an unrelated child.

C. Cashing the warrant:

(1) When the assistance warrant of a deceased recipient is presented at the county office and a determination is made that the deceased individual was eligible for the assistance payment, the county director shall endorse the warrant.

(2) The warrant must be endorsed with the name of the deceased individual and by signature of the county director. The signature of the county director need not be notarized, but must indicate the county director's official title and the address of the county office. The warrant may then be cashed by the authorized beneficiary.

D. Withdrawing EBT benefits: If the benefit was authorized via EBT deposit, the county director shall authorize access to the account by the authorized beneficiary.

E. When payment is made in accordance with these procedures, the county office shall not restrict or dictate the use of the money paid.

[8.106.230.9 NMAC - N, 07/01/2004]

History of 8.106.230 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 400 RECIPIENT POLICIES - DEFINING THE BENEFIT GROUP

8.106.400.1 ISSUING AGENCY: New Mexico Human Services Department.

[8.106.400.1 NMAC - N, 07/01/2004]

8.106.400.2 SCOPE: The rule applies to the general public.

[8.106.400.2 NMAC - N, 07/01/2004]

8.106.400.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

[8.106.400.3 NMAC - N, 07/01/2004]

8.106.400.4 DURATION: Permanent.

[8.106.400.4 NMAC - N, 07/01/2004]

8.106.400.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.

[8.106.400.5 NMAC - N, 07/01/2004]

8.106.400.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low income individual at the time of death.

[8.106.400.6 NMAC - N, 07/01/2004]

8.106.400.7 DEFINITIONS: [Reserved]

[8.106.400.7 NMAC - N, 07/01/2004]

8.106.400.8 WHO CAN BE A RECIPIENT: To be a recipient of general assistance, an individual must be eligible according to the regulations for the GA program. An individual for whom an application has been or must be made may receive cash assistance as long as the individual also meets individual eligibility requirements of the GA program and is otherwise eligible.

[8.106.400.8 NMAC - N, 07/01/2004]

8.106.400.9 BASIS FOR DEFINING THE BENEFIT GROUP

A. The request for assistance is the first step in determining those individuals who must be included in the benefit group. The head of household may determine which individuals are included in the benefit group. Any individual who is determined to be a mandatory benefit group member must be included in the benefit group. A decision by the head of household to request assistance for a specific individual may require the inclusion of other individuals as well.

B. The head of household may, subject to certain limitations, request the addition or removal of an individual included in the benefit group. ISD shall consider adding to or removing a member from the benefit group when the head of

household requests it. ISD shall remove a member of the benefit group upon request of the head of household, except when the individual is a mandatory benefit group member.

C. The head of household is required to apply for any person who is a mandatory benefit group member.

D. Failure to file an application for or to include a mandatory benefit group member shall result in ineligibility for the entire benefit group.

E. Changes in family circumstances may affect who must be included in the benefit group. Any change in family circumstances shall be reviewed to ensure that all mandatory members are included in the benefit group.

F. A pregnant woman may constitute a benefit group, in either the GA-disabled adult or the GA-dependent child program, if the pregnant woman has not reached her third trimester of pregnancy at the time of application to the GA program. The father of the unborn child must be included in the benefit group to determine need, but not payment, if he lives in the home.

G. SSI eligibility:

(1) Any individual who is potentially eligible for SSI on the basis of either age or disability must apply for SSI and accept SSI benefits if determined eligible.

(2) An individual receiving SSI, or who would be receiving SSI except for recovery by the social security administration of an overpayment, is not eligible to be included in a GA benefit group.

H. Adult with part time custody of a biological child: An adult who shares custody of his or her biological child with the other parent may apply for GA-disabled adults in his or her own right, provided that the adult who is applying has less than half time custody of the child.

[8.106.400.9 NMAC - N, 07/01/2004]

8.106.400.10 RESIDENCE IN A FACILITY OR INSTITUTION

A. GA program:

(1) An individual shall not be eligible for inclusion in a GA benefit group if the individual is:

(a) a patient in a fully publicly-funded medical institution for any reason, including such facilities as the state hospital in Las Vegas, meadows medical home in Las Vegas, or the facilities at Fort Stanton; it does not include fee-for-service public medical facilities, such as UNM hospital in Albuquerque;

(b) an inmate in a public non-medical institution, including facilities in the state prison system, jails and detention centers, as well as juvenile correction facilities such as the Springer boys home and other similar correctional facilities;

(c) A person shall be considered an inmate if residing in a public facility at the order or discretion of a court, such as a person sentenced to a prison or committed under court order.

(2) An individual attending a public educational or vocational training institution, who lives in housing provided by the institution, shall not be considered as living in a facility or as an inmate or patient of a public institution.

(3) An individual residing in a homeless shelter or other supportive living program administered by a homeless services provider shall not be considered as living in a facility or institution.

B. GA-dependent children: Under certain conditions, a dependent child may remain part of the benefit group if residing in a facility or institution. See 8.106.400.14 NMAC for regulations concerning the living in the home requirement for dependent children.

C. Adult residential shelter care home (ARSCH): To be eligible for the ARSCH supplemental payment program, an individual must be living in a facility licensed as an adult residential shelter care facility by the New Mexico department of health.

[8.106.400.10 NMAC - N, 07/01/2004]

8.106.400.11 CONSTRUCTING THE BENEFIT GROUP - GENERAL ASSISTANCE

A. GA-disabled adult benefit group: The benefit group for the GA-disabled adult program consists of the disabled adult and the spouse of the disabled adult, if the spouse lives in the home. The disabled adult's needs are considered when determining need and benefit amount.

(1) Spouse of the disabled adult: The spouse of the disabled adult may be included when determining need and benefit amount, provided the spouse is also disabled or is considered to be an essential person.

(2) Essential person: An individual is considered essential to the well being of a disabled GA recipient and may be included in the GA benefit group if the GA recipient is disabled to the extent that placement into institutional care would be required were it not for care provided by the essential person, and the essential person is capable of providing the physical care needed by the GA disabled recipient.

(a) The essential person need not be related to the disabled person, but must live with the disabled person.

(b) If the essential person is included in the benefit group, resources and income belonging to the essential person shall be considered in determining eligibility for the benefit group.

B. Minor unmarried pregnant woman: An emancipated unmarried pregnant woman, age 17 or younger, who has not reached her third trimester and has been determined to be disabled may be considered a benefit group member in the GA disabled adult program. The pregnant woman must be determined disabled and unable to work from either a medical or mental health condition resulting from the pregnancy or from another disabling condition. Merely being pregnant is not in and of itself considered a disability.

C. GA dependent child benefit group: The benefit group for the GA-dependent child program consists of a dependent child who lives in a family setting with a non-related adult caretaker, and all of that dependent child's full, half, step- or adopted siblings living in the home.

(1) Unrelated caretaker: The unrelated caretaker shall be included in the benefit group upon his or her request. The spouse of the unrelated caretaker, if living in the home, shall be included in the benefit group when the unrelated caretaker is included in the benefit group.

(a) The income of the unrelated caretaker who lives in the home with the dependent child shall be considered available to the benefit group if the non-related caretaker is included in the GA benefit group.

(b) If the spouse lives in the home and the unrelated caretaker is included in the benefit group, the income of the spouse of the unrelated caretaker shall be considered available to the GA benefit group.

(2) Minor unmarried pregnant woman: An unmarried pregnant woman age 17 or younger may be defined as a dependent child for the GA-dependent child program until she reaches her third trimester of pregnancy. The needs of the unborn child shall not be considered in determining the standard of need or the benefit amount.

D. Limitations: An individual shall not be included in a GA disabled adult or dependent child benefit group if the individual:

(1) must be included in a NMW benefit group as a mandatory member; or

(2) is ineligible for GA because the disabled adult has failed to comply with a contingency requirement determined by the incapacity review unit without good cause; or

(3) is ineligible for GA for dependent children because the individual's caretaker has failed to comply with child support enforcement requirements without good cause; or

(4) is disqualified from participation in the GA program as a result of program fraud or fleeing felon status; or

(5) has been denied or SSI benefits benefits have been terminated because of failure to meet SSI substance abuse treatment requirements or has been determined ineligible for SSI because of program fraud.
[8.106.400.11 NMAC - N, 07/01/2004]

8.106.400.12 CONSTRUCTING THE BENEFIT GROUP - STATE SUPPLEMENT FOR ADULT RESIDENTIAL CARE: To be eligible for inclusion in an ARSCH supplemental payment benefit group, an individual must be eligible for SSI. The benefit group consists of the SSI recipient. Two SSI recipients who would constitute a family if living at home, but who reside in an adult residential shelter care facility, are considered to be two separate benefit groups.
[8.106.400.12 NMAC - N, 07/01/2004]

8.106.400.13 CONSTRUCTING THE BENEFIT GROUP - BURIAL ASSISTANCE: To be eligible for inclusion in the burial assistance benefit group, a deceased individual must have been a recipient of NMW, GA, refugee assistance, ARSCH or medicaid benefits from the state of New Mexico. The benefit group consists of the deceased individual.
[8.106.400.13 NMAC - N, 07/01/2004]

8.106.400.14 LIVING ARRANGEMENT - REQUIREMENTS:

A. GA-disabled adults: There are no specific requirements for the living arrangement for a disabled adult or an emancipated minor unmarried pregnant woman.

B. GA dependent child:

(1) To be included in a GA dependent child benefit group, the child must be living, or considered to be living, in the home of an adult caretaker who is not a specified relative within the fifth degree of relationship and who is not eligible for NMW in his or her own right. Standards used to determine whether an individual is within the fifth degree of relationship are set forth in 8.106.400.16 NMAC.

(2) To be considered a caretaker, an individual must be living, or considered to be living, in the home with the child. The caretaker is the individual who has assumed primary responsibility for the care of the child.

(3) In certain situations, a child may be temporarily domiciled away from home, but nonetheless be considered as living in the home. Such a situation results when the caretaker has decided to domicile the child elsewhere because of a specific need for the child, and identified by the caretaker, provided that the caretaker remains responsible for providing care and support to the child and retains custody and control over the child.

(4) Standards used to determine whether a child lives in the home are set forth in 8.106.400.15 NMAC.

C. Shelter care for adults: In order to be included in the adult residential shelter care home assistance benefit group, the individual must be living in a facility licensed by the state of New Mexico as an adult residential shelter care facility.
[8.106.400.14 NMAC - N, 07/01/2004]

8.106.400.15 GA-DEPENDENT CHILD LIVING IN THE HOME

A. Basic requirements: A child lives with a caretaker when the caretaker's home is the primary place of residence for the child, and the child is physically present in the home at least half time during the month.

B. Joint custody: A child who is in the joint custody of caretakers who are living apart and who spends an equal amount of time with each caretaker, shall not be considered to be living with either caretaker. If the child is actually spending a majority of the time with one caretaker, the child shall be determined to be living with the caretaker with whom the child spends the most time.

C. Living in the home of the caretaker:

(1) To be included in the GA-dependent child benefit group, the child must be living in a family setting with a non-related adult who:

(a) is not eligible for NMW in the adult's own right;

(b) has assumed responsibility for care, support and supervision of an unrelated child and for meeting the child's physical and emotional needs; and

(c) has demonstrated an intent to maintain the caretaker-child relationship and to provide a home for the child; and

(d) is not the legal guardian of the dependent child.

(2) The determination whether living-in-the-home status is retained is discussed with the caretaker and carefully documented in the case record.

(3) A child shall not be considered to be living in the home when the child is physically absent from the home and is under the care, control or supervision of himself, a relative or another adult, a social services or correctional agency, or other agency of state, local or tribal government.

D. Child's absence from the home: Under certain circumstances, a child may be physically absent from the home for a period of time.

(1) The child may remain a member of the benefit group if:

(a) the nature of the absence is directly related to the well being of the child; and

(b) the caretaker continues to exercise care, support and supervision of the child during the time the child is physically away from the home; and

(c) the length of the absence is less than 45 days, provided that the child is not simultaneously participating in another cash assistance program.

(2) For a child to retain living-in-the-home status while receiving rehabilitation services, including psychosocial treatment services, certain conditions must be met:

(a) the program must be family-based with one objective being the strengthening of family ties;

(b) treatment plans must provide for a significant level of continuing authority, responsibility, and participation by the caretaker; and

(c) the caretaker must retain the authority to decide when the child should leave the facility, must approve necessary treatment, and must retain responsibility for provision of pocket money, clothing, etc.

(3) The determination whether the caretaker retains care, support and supervision responsibilities for
a child who is physically absent from the home shall include a review of the degree to which the caretaker:

(a) provides financial support to the child from the cash assistance payment;

(b) continues to maintain living quarters for the child until the child reestablishes full-time physical presence in the home; and

(c) continues to make decisions regarding the care, support and supervision of the child, including decisions about medical care and treatment, class scheduling, and other similar decisions; and

(d) maintains contact with the child through regular visits or telephone calls.

(4) Boarding school: A child who is attending school away from home continues to meet the living in the home requirement, without regard to the length of the absence, if the caretaker retains responsibility for care, support and supervision of the child. The child must have been living in the home before attending boarding school.

(5) Residence in a medicaid facility: A child hospitalized for care or treatment in a title XIX (medicaid) facility may retain living-in-the-home status, without regard to the length of hospitalization, provided that:

(a) the child must have been living in the home before hospitalization; and

(b) the caretaker continues to be the person with primary responsibility for care, support and supervision of the child

and for meeting the child's physical and emotional needs.

(c) Treatment centers may include acute care hospitals, freestanding psychiatric hospitals and rehabilitation hospitals as well as residential treatment centers and group homes reimbursed by medicaid for psychosocial rehabilitation services. The status of a residential treatment center or group home as a medicaid provider may be made by contacting the medical assistance division of the human services department.

(d) A child receiving treatment in a title XIX facility, or placed in other substitute care living arrangements by juvenile authorities as the result of a sentence or commitment by a judicial authority does not meet the definition of living in the home, as the caretaker no longer has significant responsibility of the care, support and supervision of the child.

(e) A child retains living-in-the-home status as long as the caretaker has the authority to control the child's treatment and duration of stay. Should a court order be issued placing the child in a psychiatric facility, a caretaker may be prevented from removing the child from the facility. In such a circumstance, the child cannot retain living-in-the-home status.

E. Caretaker's absence from the home: The caretaker may be physically absent from the home and still retain status as the primary caretaker for purposes of eligibility, provided the caretaker is absent from the home due to illness or hospitalization for 30 days or less.

(1) In order for the caretaker to retain living-in-the-home status, he or she must retain responsibilities for providing care, support and supervision for the child.

(2) Residence in a medicaid facility: A caretaker receiving treatment in a Title XIX facility remains a member of the benefit group of which the caretaker was a member at the time of hospitalization until the caretaker leaves the facility and returns to the home. If the caretaker does not return to the home following hospitalization, the living-in-the-home determination shall be terminated.

F. Reporting departure of a child from the home: The caretaker of a dependent child included in the GA benefit group must report when a dependent child leaves the home of the caretaker. The dependent child's needs shall be removed from the cash assistance payment when the dependent child will be away from home for 45 days or more. If the benefit group includes only one dependent child, eligibility shall be terminated for the benefit group.
[8.106.400.15 NMAC - N, 07/01/2004]

8.106.400.16 ESTABLISHING RELATIONSHIP - GA DEPENDENT CHILD PROGRAM:

A. GA may not be provided to a dependent child when a NMW application has been made and verification of relationship is pending in the NMW cash assistance program.

B. An individual who claims relationship to a dependent child, but whose relationship has not yet been verified, cannot be considered as an unrelated caretaker, and GA cannot be approved for either the caretaker or dependent child while verification is pending.

C. GA eligibility may be established if a determination is ultimately made that relationship within the fifth degree does not exist between the caretaker and the dependent child.

D. Determining relationship: The following relatives are within the fifth degree of relationship to a dependent child, and therefore cannot be considered an unrelated caretaker for purposes of the GA-dependent child program:

(1) father or mother (biological or adoptive);

(2) grandfather, great grandfather, great-great grandfather, great-great-great grandfather;

(3) grandmother, great-grandmother, great-great-grandmother, great-great-great grandmother;

(4) spouse of child's parent (step-parent);

(5) spouse of child's grandparent, great grandparent, great-great grandparent, great-great-great grandparent (step-grandparent);

(6) brother, half-brother, brother-in-law, stepbrother;

(7) sister, half-sister, sister-in-law, stepsister;

(8) uncle of whole or half-blood, uncle-in-law, great uncle, great-great uncle;

(9) aunt of whole or half-blood, aunt-in-law, great aunt, great-great aunt;

(10) first cousin and spouse of first cousin;

(11) son or daughter of first cousin (first cousin once removed);

(12) son or daughter of great aunt or great uncle (first cousin once removed) and spouse;

(13) nephew/niece and spouse;

(14) grand nephew, great-grand nephew; or

(15) grand niece, great-grand niece.

(16) A second cousin is a child of a first cousin, once removed, or a child of a child of a great aunt or uncle and is not within the fifth degree of relationship.
[8.106.400.16 NMAC - N, 07/01/2004]

History of 8.106.400 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 410 RECIPIENT POLICIES - GENERAL RECIPIENT REQUIREMENTS

8.106.410.1 ISSUING AGENCY: New Mexico Human Services Department.
[8.106.410.1 NMAC - N, 07/01/2004]

8.106.410.2 SCOPE: The rule applies to the general public.
[8.106.410.2 NMAC - N, 07/01/2004]

8.106.410.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.
[8.106.410.3 NMAC - N, 07/01/2004]

8.106.410.4 DURATION: Permanent.
[8.106.410.4 NMAC - N, 07/01/2004]

8.106.410.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.106.410.5 NMAC - N, 07/01/2004]

8.106.410.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low income individual at the time of death.
[8.106.410.6 NMAC - N, 07/01/2004]

8.106.410.7 DEFINITIONS:

A. Definitions A - L:

(1) Alien: means an individual who is not a United States citizen.

(2) Immigrant: means an indi-

vidual who is an alien as defined in title IV of the federal Personal Responsibility and Work Opportunity Reconciliation Act and within the technical meaning at 8 U.S.C. 1101(a)(15.

(3) Immigration and naturalization service (INS): means a division of the U.S. department of homeland security.

(4) Ineligible alien: means an individual who does not meet the eligible alien requirements or has not been admitted for permanent residence.

B. Definitions M - Z:

(1) Permanently residing under color of law (PRUCOL): means a noncitizen who is permanently residing in the United States, the individual's presence in the United States is known to the department of homeland security (DHS) and the DHS does not intend to remove or deport the individual.

(2) Qualified alien: means:

(a) an alien who is lawfully-admitted for permanent residence (LPR) under the Immigration and Nationality Act;

(b) an alien who has been granted asylum under section 208 of the Immigration and Nationality Act;

(c) an alien who has been admitted into the United States as a refugee under section 207 of the Immigration and Nationality Act;

(d) an alien who has been paroled into the United States for a period of at least one year under section 212(d)(5) of the Immigration and Nationality Act;

(e) an alien whose deportation has been withheld under section 243(h) of the INA as in effect prior to April 1, 1997, who whose removal has been withheld under section 241(b)(3) of the INA;

(f) an alien who has been granted conditional entry pursuant to section 203(a)(7) of the INA as in effect prior to April 1, 1980;

(g) an alien who was a Cuban or Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980;

(h) an alien, an alien parent or alien child, who has been battered or subjected to extreme cruelty in the United States by a spouse or a parent or by a member of the spouse or parent's family residing in the same home as the alien at the time of the abuse and there is a petition pending under 204(a)(1)(A) or (B) or 244(a)(3) of the INA, as long as the alien has begun the process of becoming a lawful permanent resident under the Violence Against Women Act.

(3) Refugee: means a lawfully admitted individual granted conditional entry into the United States.

(4) Sponsor: means a person who executed an affidavit of support or similar agreement on behalf of an alien as a condition of the alien's entry or admission into the United States as a permanent resident.

(5) Sponsored alien: means an alien lawfully admitted for permanent residence in the United States as an immigrant, as defined in Sections 101(a)(15) and 101(a)(2) of the Immigration and Nationality Act.

(6) State-funded alien eligible: means a non-citizen who entered the United States on or after August 22, 1996, as one of the classes of aliens described in Subsection B of 8.106.410.10 NMAC, and who is eligible for state-funded cash assistance under NMW and GA without regard to how long the non-citizen has been residing in the United States.

[8.106.410.7 NMAC - N, 07/01/2004]

8.106.410.8 REQUIREMENTS: An applicant or recipient of general assistance must meet all individual eligibility requirements, as set forth below, in order to be included in the GA benefit group. An applicant or recipient who fails to meet an individual eligibility requirement is not eligible to be included in the benefit group. The individual's ineligibility does not make the entire benefit group ineligible, unless the ineligible individual is the only member of the benefit group.

[8.106.410.8 NMAC - N, 07/01/2004]

8.106.410.9 ENUMERATION:

A. To be eligible for inclusion in the benefit group, the recipient, or the caretaker on behalf of a dependent child, must report the individual's social security number (SSN) within 60 days of approval for the GA program.

B. An SSN card shall not be required to validate the individual's SSN, but shall be requested if an individual's SSN becomes questionable or cannot be validated by the social security administration.

C. Failure to meet the enumeration requirement shall result in ineligibility of the benefit group member whose SSN has not been reported or cannot be verified.

[8.106.410.9 NMAC - N, 07/01/2004]

8.106.410.10 CITIZENSHIP AND ALIEN STATUS:

A. To be eligible for inclusion in a GA benefit group and to receive GA cash assistance, if otherwise eligible, an individual must be:

(1) a citizen of the United States;

(2) a naturalized citizen;

(3) an alien who entered the United States as a legal permanent resident or PRUCOL before August 22, 1996; or

(4) an alien who entered the United States on or after August 22, 1996, and who meets the definition of a qualified alien, and is subject to the five-year bar from participation in the federally funded TANF cash assistance program.

B. General provisions for state-funded aliens:

(1) Payment to state-funded aliens is subject to the availability of state GA funding. Payment to a state-funded alien will be terminated if the state-funded GA program for eligible aliens is suspended or terminated.

(2) An alien who entered the United States on or after August 22, 1996, and is subject to the five-year bar on receiving federally-funded TANF cash assistance, may be eligible for state-funded general assistance without regard to how long the alien has been residing in the United States.

(3) An alien who is a mandatory benefit group member in the federally-funded TANF program but is ineligible for TANF funded assistance under the alien regulations for the TANF program, may be eligible for state-funded GA. These aliens will be included in the TANF benefit group with recipients of the TANF funded program for payment purposes, and shall be:

(a) required to comply with the work requirements of the NMW work program if determined to be a mandatory work participant; and

(b) subject to removal from the TANF benefit group if the GA program is suspended or terminated.

(4) An adult alien who receives state-funded general assistance is not eligible for medicaid.

(5) An alien who is otherwise eligible for federal TANF cash assistance, including the citizenship and alien provisions of this section, and would be a mandatory benefit group member, shall not be eligible for state-funded assistance.

(6) An adult alien who is disabled, or a dependent child who is not eligible for the TANF-funded program may be included in a GA benefit group, provided the individual meets all other GA requirements.

(7) Age requirement for state-funded aliens: For purposes of determining the eligibility of a qualified alien to participate in the state-funded GA program, no age limit shall be imposed on the individual.

C. Aliens who entered the United States before August 22,1996: An alien who entered the United States before August 22, 1996 may be eligible for GA cash assistance, if otherwise eligible, based on the alien regulations in effect prior to August 22, 1996 which include:

(1) aliens lawfully admitted for permanent residence (LPR);

(2) aliens permanently residing in the United States under color of law (PRU-

COL);

(3) certain aliens lawfully present in the United States based on the application of the following provisions of the Immigration and Nationality Act (INA):

(a) an alien admitted as refugees under section 207(c), in effect after March 31, 1980;

(b) an alien who was granted conditional entrant status as a refugee under section 203(a)(7) in effect prior to April 1, 1980;

(c) an alien granted political asylum by the attorney general under section 208;

(d) an alien granted temporary parole status by the attorney general under section 212(d)(5) of the Immigration Reform and Control Act of 1986;

(e) an alien granted lawful temporary status pursuant to section 201, 302, or 303 of the Immigration Reform and Control Act of 1986;

(f) a Cuban and Haitian entrant as defined in paragraph (1) or (2) (A) or section 501(e) of Public Law 96-422, the Refugee Education Assistance Act of 1980; or

(g) an applicant for GA who is not a Cuban or Haitian entrant and who was adjusted to lawful resident status more than five years prior to application.

D. Aliens who entered the United States on or after August 22, 1996:

(1) An alien who entered the United States on or after August 22, 1996 shall be barred from receiving cash assistance funded by the federal TANF block grant for a period of five years, beginning on the date that the alien obtained qualified alien status. Such an alien may meet an exception to the federal five-year bar, in which case the alien will be eligible for TANF cash assistance.

(2) Eligibility for state-funded GA: A qualified alien who entered the United States on or after August 22, 1996, to whom the five-year bar applies, may participate in the state-funded GA program for the duration of the five-year bar, if otherwise eligible.

[8.106.410.10 NMAC - N, 07/01/2004]

8.106.410.11 RESIDENCY:

A. To be eligible for inclusion in a GA benefit group, an individual must be living in the state of New Mexico, and have demonstrated an intent to remain in the state. For applicants, the residency determination shall be made on the date eligibility is determined. Once established, state residency continues until the individual takes action to end it.

B. Residence shall not be considered to exist if the person is just passing through the state or is present in the state for purposes such as vacation, family visits, medical care, temporary employment, or other similar short-term stays and the person does not intend to remain. Residence shall not exist if an individual claims residence in another state.

C. Establishing residence: Residence in New Mexico shall be established by being present in the state on an ongoing basis and carrying out the types of activities associated with normal day-to-day living, such as occupying a house (paying rent or mortgage and utilities, receiving mail at that address, etc.), enrolling children in school, renting a post office box, obtaining a state driver's license, joining a church or other local organization, obtaining or seeking employment in the state, registering to vote in the state, etc.

D. Homeless persons: Homeless persons must meet the residence requirement; however, their personal situations may prevent them from establishing the types of residence indicators listed above. In such cases, as much information as possible shall be obtained and entered into the case record, but absence of the more common types of verifications, including but not limited to residence, shall not be a barrier to eligibility.

E. Temporary absence from the state:

(1) A temporary absence from the state shall not be considered an interruption of residence. Temporary absence occurs when an individual leaves the state for a specific, time-limited purpose, with the intention of returning to the state.

(2) Absences related to the following purposes shall be considered temporary:

(a) short-term visits with family or friends lasting less than 30 days;

(b) out-of-state stays for medical treatment; or

(c) attendance at an out-of-state school, returning to the state during vacations.

(3) A statement by a recipient of intent to return to the state will be accepted, provided that the recipient does not take action in another state to establish permanent residence.

F. Residency abandonment: Residence shall be considered to have been abandoned when an individual:

(1) leaves the state and indicates that he intends to establish residence in the other state; or

(2) leaves the state for no specific purpose and with no clear intention to return; or

(3) leaves the state and applies for food, financial or medical assistance from another state; or

(4) has been absent from the state for a period of 30 days or more and has not notified the department of the absence or of an intention to return.

G. Residence of children: A dependent child shall be considered to be a resident of the same state as the caretaker adult with whom the child is living.

[8.106.410.11 NMAC - N, 07/01/2004]

8.106.410.12 NONCONCURRENT RECEIPT OF ASSISTANCE

A. Assistance from another state: An individual who is receiving assistance from another state shall be considered a resident of that state until the state is notified of the individual's intention to abandon residence. An individual who received GA from another state shall be considered to be in receipt of concurrent assistance for that month.

B. Concurrent receipt of assistance: To be eligible for inclusion in a GA benefit group, the individual cannot already be:

(1) included as a benefit group member and receiving cash assistance from another department cash assistance program;

(2) an SSI recipient;

(3) a recipient of benefits from a federally-funded TANF program (including a tribal program) or BIA-GA program;

(4) a recipient of a government-funded adoption subsidy program; or

(5) a recipient of benefits from a TANF or GA program in another state.

C. An individual may not be the payee for more than one GA cash assistance payment.

D. Supplemental security income:

(1) Ongoing SSI eligibility: An individual eligible for SSI on an ongoing basis is not eligible for GA benefits based on concurrent receipt of assistance. The SSI recipient shall not be included in the benefit group for purposes of GA eligibility or benefit calculation. The income, resources and needs of the SSI recipient are excluded in determining benefit group eligibility and benefit amount.

(2) SSI applicants: An individual receiving GA cash assistance benefits from the department may apply for and receive SSI benefits for the same months for which the department has already issued GA benefits. Cash assistance benefits issued by the department are considered in determining the amount of retroactive SSI benefits to be paid to the SSI applicant. GA ineligibility or overpayments shall not be established for any month for which the SSA issues an SSI retroactive payment. When notice is received that a benefit group member is approved for SSI on an ongoing

basis, that member shall be immediately removed from the benefit group.

(3) Retroactive SSI payments:

(a) A state funded GA recipient who receives retroactive SSI payments is required to reimburse the department under general assistance program interim assistance reimbursement (IAR) provisions set forth at 8.106.420.17 NMAC.

(b) There may be some situations in which only retroactive SSI benefits are approved. Such approvals do not result in GA ineligibility due to concurrent receipt of assistance, since the SSI benefits will not be received on an ongoing basis, but may result in GA ineligibility on the basis of resources (See 8.106.510 NMAC).

(4) Adult residential shelter care program: Receipt of SSI is a requirement for receiving adult residential shelter care payments.

E. Other department programs: The food stamp program, medicaid, LIHEAP and other similar programs are not considered concurrent assistance and shall not make an individual ineligible for GA cash assistance programs.

[8.106.410.12 NMAC - N, 07/01/2004]

8.106.410.13 PROGRAM DISQUALIFICATIONS

A. Dual state benefits: An individual who has been convicted of fraud for receiving TANF, food stamps, medicaid or SSI in more than one state at the same time shall not be eligible for inclusion in the GA cash assistance benefit group for a period of 10 years following such conviction. The conviction must have occurred on or after August 22, 1996.

B. Fugitive and probation and parole violators: An individual who is a fugitive felon or who has been determined to be in violation of conditions of probation or parole shall not be eligible for inclusion in the GA cash assistance benefit group.

[8.106.410.13 NMAC - N, 07/01/2004]

History of 8.106.410 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 420 RECIPIENT POLICIES - REQUIREMENTS FOR DETERMINING DISABILITY

8.106.420.1 ISSUING AGENCY: New Mexico Human Services Department.

[8.106.420.1 NMAC - N, 07/01/2004]

8.106.420.2 SCOPE: The rule applies to the general public.

[8.106.420.2 NMAC - N, 07/01/2004]

8.106.420.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

[8.106.420.3 NMAC - N, 07/01/2004]

8.106.420.4 DURATION: Permanent.

[8.106.420.4 NMAC - N, 07/01/2004]

8.106.420.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.

[8.106.420.5 NMAC - N, 07/01/2004]

8.106.420.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low income individual at the time of death.

[8.106.420.6 NMAC - N, 07/01/2004]

8.106.420.7 DEFINITIONS:

A. A - L:

(1) Capacity: means an individual's mental or physical ability especially as it relates to employment, taking into consideration non-medical factors such as an individual's age, education, work experience, vocational training, ability to speak English, etc. These non-medical factors are generically referred to as "other work-related factors."

(2) Disability processing unit: means the unit within the income support division that is responsible for managing a case and guiding an applicant through the GA application process.

(3) Gainful employment: means any job or class of jobs in the state that would provide an income equaling or exceeding 85% of the federal poverty guideline for the size of the benefit group.

(4) Impairment: means a physical or mental condition resulting from anatomical, physiological, developmental, or psychological abnormalities evidenced by medically-acceptable clinical or laboratory diagnostic techniques. To determine a physical and/or mental impairment, medical evidence documenting signs, symptoms and objective findings must be obtained and evaluated from a physician in relation to an individual's ability to be gainfully employed.

(5) Incapacity review unit: means the unit within the income support division that is responsible for determining whether an applicant or recipient is disabled according to the guidelines for the general assistance-disabled adults program.

(6) Interim assistance reimbursement: means the program within the social security administration that will reimburse the state through HSD for payments made to an individual receiving GA disability during the period the individual's application for SSI was pending.

(7) License or licensed: means a document or documentation identifying the legal authorization to practice within a professional category.

B. M - Z:

(1) Permanent total disability: means a physical, mental or developmental impairment expected to last at least 12 months from the date of application, which prevents gainful employment in any job within the individual's employment capacity.

(2) Physician: means a licensed medical or mental health practitioner including, but not limited to: medical doctors, doctors of osteopathy or podiatry, ophthalmologists, psychiatrists or psychologists, counselors, certified nurse practitioners, physician assistants with a supervising physician's signature, or mental health professionals with qualifications set by an agency.

(3) Temporary total disability: means a physical, mental or developmental impairment expected to last at least 30 days but no more than 12 months from the date of application, that prevents gainful employment in any job within the individual's employment capacity.

(4) Time-limited disability: means an physical or mental impairment that is expected to last at least 30 days but less than six months from the date of application and has been diagnosed by a physician or mental health practitioner, that prevents gainful employment in any job within the individual's employment capacity.

(5) Work-related factors: means factors taken into account in the disability determination process such as age, education, training, work experience, lan-

guage ability, appearance, marital status, living situation, as well as relevant social history and minimal employment and activities that would be required in a work setting such as sitting, standing, walking, lifting, carrying, handling, seeing, hearing, communicating and understanding and following directions.
[8.106.420.7 NMAC - N, 07/01/2004]

8.106.420.8 AGE - GA DISABILITY:

A. GA-disabled adult: An individual may be eligible for inclusion in a GA-disabled adult benefit group if the individual has reached the age of 18. An emancipated minor pregnant woman may be considered for inclusion in a GA-disabled adult benefit group.

B. State-funded alien: There is no age limit for participation in the state-funded GA program by qualified aliens.
[8.106.420.8 NMAC - N, 07/01/2004]

8.106.420.9 DISABILITY - GENERAL PROVISIONS FOR ADULTS:

A. Intent of the GA program:

(1) The GA program is intended to provide cash assistance to individuals who are unable to be gainfully employed because of a time-limited, temporary or permanent disability.

(2) The GA program is not intended to be an unemployment or general relief program.

(3) A finding that an individual has the capacity to work cannot be interpreted to mean that the department believes that employment suitable to that individual is easily available in the individual's community or that the individual would obtain employment if it were.

(4) An individual's success in finding work within the individual's capacity neither adds to nor detracts from the disability determination.

(5) An impaired individual, who has the capacity for work but who cannot find a job, is unemployed, and shall not be determined to be disabled.

(6) Based upon medical reports, physician's statements, a medical/social summary, and any other supporting documentation, a determination whether an individual is disabled is made in accordance with the guidelines in 8.106.420 NMAC.

B. Program participation limit: A benefit group, if found eligible, may receive cash assistance payments under only one GA category or program.
[8.106.420.9 NMAC - N, 07/01/2004]

8.106.420.10 D I S A B I L I T Y DETERMINATION STANDARDS

A. General provisions: The disability determination process requires a finding that an individual, because of an impairment, does not have the capacity for gainful employment, or, in the case of a homemaker, the capacity to perform necessary homemaking activities.

(1) The disability determination process takes into account whether an individual has a physical, mental or developmental impairment that precludes gainful employment within the individual's capacity. Medical findings are evaluated to determine the level of activity the individual can perform.

(2) An evaluation of other work-related factors may be considered in determining whether employment exists which could be performed by the individual, given the individual's physical and/or mental impairment(s).

(3) The GA disability determination is made independent of and using standards that differ from the standards used for determining OASDI or SSI eligibility, workman's compensation, veteran's compensation or Americans with Disability Act (ADA) determinations. Medical and social information used by disability reviewers may differ between determinations, and an individual's condition may improve or worsen over time. As a result, an individual may be determined disabled by one program but not by another.

(4) While disability standards for the GA program are less demanding than those of OASDI or SSI, a given individual may quite correctly be found ineligible for GA and eligible for OASDI, SSI or another disability program. A disability determination made for another program or purpose is immaterial to the GA disability determination. GA determinations shall be made considering only GA regulations and medical and non-medical information known or provided to ISD.

B. Obtaining medical information and/or reports:

(1) Records, narrative reports and relevant medical information resulting from examinations and/or diagnostic procedures shall be used to evaluate an impairment and determine disability.

(2) The department shall pay for examinations or medical records required to make a disability determination.

(3) The department shall take appropriate steps to gather existing medical documentation, including but not limited to:

(a) assisting the applicant or recipient to request existing medical documentation;

(b) requesting medical records directly from the medical provider; and

(c) scheduling the applicant or recipient for medical examinations or other appropriate procedures.

(4) Written medical evidence shall be obtained from:

(a) medical doctors;

(b) doctors of osteopathy or podiatry;

(c) ophthalmologists;

(d) psychiatrists or psychologists;

(e) treatment providers, such as licensed counselors, certified nurse practitioners and chiropractors;

(f) a physician assistant, when the medical report is co-signed by the supervising physician;

(g) individuals who provide mental health services in a community mental health services agency and meets the minimum mental health professional qualifications set by the agency.

(5) Existing medical reports or information provided by a practitioner who is providing current or on-going treatment can be used to evaluate impairment. If possible, an applicant or recipient shall be referred to the individual's own physician for medical examinations and diagnosis. The department shall request copies of relevant existing medical reports and shall use such reports in making a disability determination.

(6) Reports over six months old may be useful in a disability determination or to support a pattern of recurring impairment, if they contain information regarding a chronic condition. Such reports are supporting documentation, but must be accompanied by current medical information.
[8.106.420.10 NMAC - N, 07/01/2004]

8.106.420.11 D E T E R M I N I N G DISABILITY - TIME LIMITED

A. Time-limited disability determination: To make a time-limited determination, a physician's statement shall be required. No other information shall be required to support the finding of a disability.

B. Contents of medical reports:

(1) The medical information must be documented on the department's standardized and approved medical release/physician's statement or may be documented on a physician's statement that includes all the information required to make a disability determination.

(2) The medical information used to substantiate a time-limited impairment and finding of disability shall include, but may not be limited to:

(a) a record or narrative report resulting from examinations or diagnostic procedures;

(b) a statement of the impairment;

(c) a projected time period of the length of the disability; and

(d) certification that the impairment precludes employment within the individual's capacity.

C. Process for time-limited disability determinations: The disability determination process requires a review of medical documentation and a finding that an individual, because of an impairment, does not have the capacity for employment, or, in the case of a homemaker, the capacity to perform necessary homemaking activities; and that the duration of the disability is for six months or less.

D. Duration of an impairment: Determination of whether an individual has a time-limited disability is based upon the duration of the impairment.

(1) An impairment that is expected to last at least thirty days from the date of disability and for six months or less shall be deemed a time-limited disability.

(2) For a significant impairment substantiated by medical documentation that precludes the individual's capacity to engage in gainful employment for a time-limited duration, disability shall be affirmed for the length of time established by the physician on the medical documentation.
[8.106.420.11 NMAC - N, 07/01/2004]

8.106.420.12 INITIAL CERTIFICATION - TEMPORARY OR PERMANENT DISABILITY

A. Initial six-month certification: An initial six-month certification period may be assigned for certain individuals whose disability is temporary or permanent.

(1) Contents of medical reports: The medical information or report must be documented on the department's standardized and approved medical release/physician's statement or may be documented on a physician's statement that includes all the information required to make a disability determination.

(2) At a minimum, the medical information used to substantiate an initial six-month certification and a finding of disability shall include, but may not be limited to:

(a) a record or narrative report resulting from examinations or diagnostic procedures;

(b) a statement of the impairment;

(c) a projected time period of the length of the disability; and

(d) a description of how the impairment precludes employment within the individual's capacity.

B. An initial six-month certification confers eligibility only as long as the GA recipient continues to comply with ongoing requirements of the temporary or permanent disability determination process.

(1) GA benefits shall be terminated by issuing a notice of adverse action during the initial six-month certification period when a determination is made that the GA recipient has failed to comply with ongoing requirements for determining a disability that is temporary or permanent.

(2) An individual whose benefits are terminated for failure to comply may not reapply for benefits based on the same impairment until at least 12 months have passed since the original date of application.
[8.106.420.12 NMAC - N, 07/01/2004]

8.106.420.13 DETERMINING DISABILITY - TEMPORARY OR PERMANENT

A. Process for temporary or permanent determinations: The disability determination process requires an evaluation of an individual's impairment and whether an individual's impairment prevents gainful employment within an individual's capacity.

(1) A set formula for determining whether a temporary or permanent disability is evident cannot be established because the combinations of impairment, capacity for employment and other work-related factors are as varied as the number of individuals for whom disability determinations are made.

(2) The disability determination shall be made based on objective and substantiated findings for the impairment, as well as an evaluation of other work-related factors affecting the impairment.

(3) A significant impairment must exist to substantiate a finding that an individual is temporarily or permanently disabled and precluded from employment.

(4) Evaluating the impairment: Disability shall be determined by evaluating the impairment and other work-related factors as they affect an individual's capacity for gainful employment.

B. Significant impairment: A significant impairment, together with an evaluation of other work-related factors and substantiation that the impairment and other work-related factors preclude employment, shall be considered a disability. Existence of an impairment does not necessarily result in a finding of disability. Many individuals with significant impairments are able to work and, thus, cannot be considered disabled according to the disability standards for the GA program.

C. Contents of medical reports - temporary or permanent impairments: Medical reports must be complete and detailed enough to allow a determination of the limiting effects of an impairment, probable duration of the impairment, and capacity to perform work-related activities.

(1) For maximum usefulness, medical reports should include medical history, clinical findings, laboratory findings, diagnosis, prescribed treatment and prognosis, and the practitioner's medical assessment.

(2) Medical assessments should discuss abilities, such as sitting, standing, moving, lifting, carrying, handling objects, hearing, speaking and traveling.

(3) Psychiatric assessments should discuss the individual's judgment and occupational, personal and social adjustments.

(4) An unsubstantiated statement of impairment shall not be adequate to establish disability. A statement in any report that an individual is disabled and cannot work shall not be a determining factor in making the disability determination.

D. Evaluating the severity of the impairment: The severity of the impairment shall be assessed in relation to the degree the impairment restricts an individual's capacity to perform basic work-related activities.

(1) Medical evidence is evaluated to determine the existence of symptoms, limitations and the effect of the condition on the individual's ability to perform work-related activities.

(2) In some circumstances, an impairment that is classified as temporary may be determined to be permanent if the severity of the impairment presents significant limitations or the individual is unable to perform basic work activities. For example, a fractured leg, which would be considered a temporary impairment, could become a permanent impairment if fusion has not taken place and is not expected to take place for a lengthy period.

(3) In some circumstances, an impairment that is classified as permanent may be determined to be temporary if the severity of the impairment presents no significant limitations or there is no effect on the individuals ability to perform basic work activities. For example, epilepsy controlled by medication could be considered a temporary impairment.

E. Assessing medical reports:

(1) Symptoms: Symptoms shall be evaluated. Symptoms are a descriptive report by the practitioner of the mental or physical impairment. Obvious impairments, such as recent fractures, do not require extensive reporting. Chronic or complex ailments require more extensive reporting. Symptoms alone shall not be used to make a determination of impairment.

(2) Signs: Signs are the observations made by the practitioner regarding anatomical, physiological, or psychological

abnormalities through medically-acceptable clinical techniques. In psychiatric impairments, signs are medically demonstrable abnormalities of behavior, affect, thought, memory, orientation and contact with reality.

(3) Laboratory findings: Laboratory findings are objective demonstrations of anatomical, physiological or psychological abnormalities. They include X-rays, blood tests and psychological tests.

(4) Level of ability to work: The physical ability of the individual to do work at a certain level shall be assessed. The level of ability of an individual to work shall be compared to the categories of work levels described and defined in the "dictionary of occupational titles."

(a) Sedentary work: Sedentary work involves lifting no more than ten pounds at a time and occasionally lifting or carrying articles like docket files, ledgers and small tools. Although a sedentary job is defined as one that involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and sedentary standards are met.

(b) Light work: Light work involves lifting no more than twenty pounds at a time, with frequent lifting or carrying of objects weighing up to ten pounds. Even though the weight lifted may be very little, a job is placed in this category if it requires a good deal of walking or standing, or if it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. If an individual can do light work, it is assumed that he can also do sedentary work, unless there are additional limiting factors, such as loss of fine dexterity or inability to sit for long periods of time.

(c) Medium work: Medium work involves lifting no more than 50 pounds at a time, with frequent lifting or carrying of objects weighing up to 25 pounds. If an individual can do medium work, it is assumed that the individual can also do sedentary and light work.

(d) Heavy work: Heavy work involves lifting no more than 100 pounds at a time, with frequent lifting or carrying of objects weighing up to 50 pounds. If an individual can do heavy work, it is assumed that the individual can also do medium, light and sedentary work.

(e) Very heavy work: Very heavy work involves lifting objects weighing more than 100 pounds at a time, with frequent lifting or carrying of objects weighing 50 pounds or more. If an individual can do very heavy work, it is assumed that the individual can also do heavy, medium, light and sedentary work.

(5) Psychological impairment: If a psychological impairment is being assessed, an individual's mental ability to function at one of the levels of ability to work shall be evaluated in the following areas:

(a) Judgment: Individual's ability to exercise appropriate decision-making processes in a work situation consistent with the individual's abilities.

(b) Stress reaction: Individual's ability to handle stress consistent with the level of employment.

(c) Cognitive function: Individual's awareness, memory, intellectual capacity and other cognitive functions.

F. Other work-related factors: The determination of capacity takes into consideration other work- related factors, such as an individual's age, education, work experience, vocational training, ability to speak English and similar matters. Other work-related factors are considered in determining whether employment exists that could be performed by the individual, given the individual's physical and/or mental impairment(s).

(1) Other factors that may affect the individual's employability shall be taken into consideration, only if a significant impairment affecting the individual's employability has been determined to exist.

(2) Other work-related factors shall be used to evaluate the ability of the individual to engage in employment with respect to the impairment.

(3) A finding of disability cannot be made based solely on other work-related factors. Different evaluations of disability may be made for two individuals with the same impairment, based on the other work-related factors affecting the individuals, i.e., one individual may be found to be disabled by the program definition and the other may not.

(4) Age: Age is a key factor in the determination process. The older an individual is, the less potential there is for overcoming an impairment. Recovery is more difficult and, often, total recovery may not be achieved. There may be very little chance that the individual will ever return to functioning effectively in his or her previous job duties.

(5) Education: An individual's educational level is an important factor in the determination process. An individual who lacks a high school degree or GED may be hampered in an ability to get a job that does not require strenuous effort. Education is defined at four levels:

(a) Illiteracy: Inability to read or write English. Illiterate individuals are considered suitable for the general labor work force.

(b) Marginal: Eight years of education or less. Marginally-educated individuals are considered suitable for the semi-skilled work force.

(c) Limited: Lack of a high school diploma, but more than eight years of education. Individuals with limited education are considered suitable for the semi-skilled to skilled work force.

(d) High school, GED and above: Indicates an individual's ability to compete in all levels of the job market.

(e) Training program: Completion of training in a particular field of employment indicates an individual is capable of doing the job if not hindered in the performance of it by an impairment(s). Completion of a training course may offset the education factor in some instances.

(6) Job experience: Experience in a job field can overcome a lack of education and/or training. Jobs held in the last ten years shall be considered. Work experience shall be evaluated based on the type of work previously performed, the length of employment and the potential for transferring the experience to other types of employment. Inability to continue working in one's prior field of work does not constitute a disability. Jobs and job experience are classified in the following categories:

(a) General labor: Does not require the ability to read or write. Such work includes, but is not limited to, field labor, construction labor, housework and motel cleaning.

(b) Semi-skilled labor: Requires a minimal ability to read, write and do simple calculations. Such work includes, but is not limited to, security guard, taxi driver, cashier and janitor.

(c) Skilled labor: Ability to do work in which the ability to read, write and do calculations of a complex nature is needed. Specialized training in the area is also considered. Such work includes, but is not limited to, that of an accountant, mechanic, plumber and other areas requiring some degree of skill.

(7) Language ability: Inability to speak, read and write English severely limits an individual's choice of jobs.

(8) Appearance: An individual's appearance may not be heavily weighted in a disability determination. On rare occasions, an impairment is disfiguring and may interfere with employment. For example, an individual with psoriasis covering the face, arms and hands might have a problem getting a job working with the public, such as cashier or waitress.

(9) Marital status/living situation: These factors shall be evaluated for individuals who previously have not been

self-supporting through employment or benefits (NMW, VA, OASDI, SSI, etc.). An individual who has relied on financial support from others before an impairment, and whose situation has not changed, cannot be considered employment-disabled.

(10) Employment of applicant/recipient: There may be situations in which a GA applicant or recipient is or becomes employed. A GA applicant or recipient's employment shall be taken into consideration in determining disability based on the type of employment, the duration of the employment and verification that the employment is minimal.

(a) Minimal employment: An individual who is minimally employed may still be considered disabled, if the individual cannot reasonably be expected to be self-supporting by at least the standard of need in the GA program.

(b) Shelter work: Work made available to an individual through the interest or compassion of others, or to rehabilitate an individual (as in a sheltered workshop), but which would not ordinarily exist on the open labor market, shall not be considered employment in a disability determination.

G. Duration of an impairment: Determination of whether an individual has a temporary or permanent disability is based upon the duration of the impairment. The duration may be determined by the nature of the impairment.

(1) Temporary disability: The impairment is expected to last at least thirty days from the date of disability and less than twelve months. The impairment must be affirmed by medical documentation and must preclude the individual's capacity to engage in gainful employment for a temporary period.

(2) Permanent disability: The impairment is expected to last twelve months or more from the date of disability. The impairment must be affirmed by medical documentation and must permanently preclude the individual's capacity to engage in gainful employment.

[8.106.420.13 NMAC - N, 07/01/2004]

8.106.420.14 GUIDELINES USED TO DETERMINE A TEMPORARY OR PERMANENT DISABILITY: Temporary or permanent impairments and capacity for employment may be evaluated using the guidelines described in this Section. In some circumstances, an impairment that is listed as temporary may be deemed permanent. Temporary and permanent impairments include, but are not limited to:

A. Musculoskeletal systems:

(1) Temporary: spinal strain or sprain; fractured bones, arms, legs, ankles, ribs, etc; carpal tunnel syndrome; myalgia; fibrositis; single-incident osteomyelitis.

(2) Permanent: amputation; deformities; degenerative joint disease; herniated nucleus pulposus; non-union fractures; ankylosis; osteo-rheumatiod arthritis; recurrent osteomyelitis; osteoporosis; spinal scoliosis; kyphosis.

B. Ophthalmological:

(1) Temporary: cataracts; pterygiums; decreased visual acuity that is correctable; conjunctivitis; ophthalmitis; optic nerve disorders.

(2) Permanent: glaucoma; diabetic retinopathy; blindness; vitreous hemorrhages.

C. Hearing disorders:

(1) Temporary: tinnitus; otitis; vertigo; temporary hearing impairment.

(2) Permanent: total deafness; corrected hearing loss with poor speed discrimination.

D. Pulmonary disorders:

(1) Temporary: asthma; bronchitis; pneumonia; dyspnea; pleurisy.

(2) Permanent: emphysema; tuberculosis; chronic obstructive pulmonary disease; chronic emphysema; chronic asthmatic bronchitis; pulmonary edema.

E. Heart disease:

(1) Temporary: aortic aneurysm; arteriosclerosis; arterial hypertension; myocardial infarction; angina pectoris; transient ischemic attack; cardiomyopathy.

(2) Permanent: rheumatic heart disease; congestive heart failure; cardiac decompensation; cardiac arrhythmia; valyular disorders; myocardial infarction with residual impairment; ischemic heart disease; malignant hypertension.

F. Digestive system:

(1) Temporary: hiatus hernia; esophageal disorders; surgery for peptic ulcers; hepatitis alcoholism; pancreatitis; ulcerative colitis; irritable bowel syndrome; non-insulin dependent diabetes; diverticulitis.

(2) Permanent: cirrhosis; alcoholic liver disease; crohn's disease; chronic hepatitis; chronic pancreatitis; inoperable cancer; familial polyposis.

G. Neurological:

(1) Temporary: concussion; cerebral laceration; subdural hematoma; migraine headache; vertigo; sleep disorder; encephalitis; aseptic meningitis; delirium.

(2) Permanent: cerebral vascular disease; spinal cord injuries; peripheral neuropathy; brain tumors; multiple sclerosis; epilepsy; cerebral palsy; muscular dystrophy; Parkinson's disease; poliomyelitis.

H. Mental disorders:

(1) Temporary: personality disorder; somatization disorder; drug and alcohol dependency; panic/anxiety attacks; depression; obsessive/compulsive disorder; conversion reaction; hypochondriasis; anorexia; dementia.

(2) Permanent: schizophrenia; psychosis; neurosis; manic depression; bipolar affective disorder; mental retardation; organic brain syndrome; alzheimer's disease.

[8.106.420.14 NMAC - N, 07/01/2004]

8.106.420.15 RESPONSIBILITY FOR DETERMINATION OF ELIGIBILITY - CASEWORKER

A. GA application process:

(1) The caseworker shall register an application for GA and shall schedule an interview with the applicant. The interview must be scheduled to occur within ten working days from the date of application.

(2) An individual who files an application in person at the ISD office shall be screened for the appropriate GA category. An application received by mail or any other acceptable method, shall be registered and an appointment for an interview shall be scheduled.

(3) At the interview, the caseworker shall explain the GA program. A caseworker may make an informed choice and register the type of disability assistance that most appropriately meets the applicant's stated disability or duration of disability.

(4) The caseworker shall send a delay notice to an applicant for an application that is not processed within 60 days from the date of application. The delay notice shall inform the applicant of the reason for the delay.

(5) The caseworker shall develop a medical/social summary describing the individual's health history, appearance, work and personal situation.

(6) The caseworker shall take appropriate action on the application and, if approved, shall inform the GA recipient of any conditions or contingency requirements for continued eligibility.

(7) Reporting responsibilities: The caseworker shall inform the benefit group of its responsibility to report changes. The caseworker shall be required to take action on any change reported by the benefit group to determine if the change affects eligibility or benefit amount. The caseworker shall document the date a change is reported and whether the change affects eligibility or benefit amount.

B. Application denial:

(1) The caseworker shall deny an application for GA benefits when the benefit group's:

(a) countable gross income exceeds 85% of the federal poverty guideline for the size of the benefit group; or

(b) total countable income

exceeds the standard of need for the size of the benefit group; or

(c) countable resources exceed the liquid or nonliquid resource limit for the GA program.

(2) The caseworker shall deny an application for GA on the 60th day after an application is filed when the applicant fails, without good cause, to comply with the GA application process, including but not limited to, attending a scheduled appointment with a medical practitioner. Good cause reasons include, but may not be limited to, transportation difficulties, illness or death.

(3) The caseworker shall deny an application upon a finding that an individual who received an initial six-month certification for a temporary or permanent disability is applying for disability based on the same impairment, but:

(a) did not comply with the ongoing requirements of the disability determination process;

(b) did not have good cause for the failure to comply; and

(c) 12 months have not elapsed since the original application for the same impairment.

C. Obtaining medical information: The caseworker shall be responsible for accepting medical reports provided by the applicant or recipient at the interview or in the local county office anytime after the interview, for preparing a medical/social summary, and for preparing necessary documents for all GA disability applications.

D. Forwarding medical information: All medical reports and social information, the social summary and other related documents shall be submitted to the disability processing unit for any application based on a temporary or permanent disability.

E. Determining eligibility: The caseworker:

(1) may approve GA for a verified time-limited disability that is expected to last six months or less;

(2) may make an initial time-limited disability determination of six months for a verified temporary disability that is expected to last at least six months but less than 12 months; or may make an initial time-limited disability determination of six months for a verified permanent disability that is expected to last 12 months or more;

(a) After approval, the caseworker must forward medical information and appropriate forms with the individual's signature to the disability processing unit for review, case management and a disability determination from the IRU.

(b) If IRU subsequently determines that an individual was not temporarily disabled, there shall be no overpayment claim established for any month covered by the initial determination, as long as the individual has not intentionally provided incorrect information in order to receive assistance.

F. Termination of GA participation: A caseworker shall terminate participation in the GA program if it is determined for an active case:

(1) that countable gross income exceeds eighty-five percent (85%) of the federal poverty guideline for the size of the benefit group;

(2) that countable net income equals or exceeds the standard of need for the size of the benefit group;

(3) that on the basis of medical and/or social information, the incapacity review unit has determined a disability no longer exists;

(4) that an individual has failed or refused to comply with a condition of eligibility or a contingency requirement, without good cause;

(5) that an individual refuses or fails to comply with the conditions for eligibility at 8.106.420.17 NMAC; or

(6) that the duration of a time-limited disability has expired; or

(7) that a GA recipient has failed to comply with ongoing eligibility requirements after an initial certification based on temporary or permanent eligibility.

[8.106.420.15 NMAC - N, 07/01/2004]

8.106.420.16 RESPONSIBILITY FOR DETERMINING ELIGIBILITY - DISABILITY PROCESSING UNIT (DPU)

A. Case management: The disability processing unit (DPU) case manager shall take appropriate steps to complete or to assist the applicant in completing the application process, or to assist a GA recipient with ongoing eligibility requirements.

B. Case management activities: Case management activities include, but are not limited to:

(1) gathering appropriate medical documentation, including but not limited to:

(a) assisting the applicant or recipient in requesting existing medical documentation;

(b) requesting medical records directly from the medical provider; and

(c) scheduling the applicant or recipient for medical or mental health examinations or other necessary procedures;

(2) completing a review of medical reports and the medical social summary, and determining the need for further medical evaluations or an expedited determination from the incapacity review unit;

(3) completing follow-up activities with the applicant or recipient as necessary or appropriate, including ongoing eligibility requirements after an initial certification based on a temporary or permanent disability;

(4) seeking resources in the individual's community that can assist the individual with appropriate services;

(5) tracking the disability review and certification end dates and taking appropriate steps to notify the GA recipient of what will be needed to find out if benefits can continue;

(6) tracking compliance with contingency requirements and assisting the GA recipient in finding appropriate medical or mental health services;

(7) reviewing the agreement for interim assistance reimbursement, ensuring a signature of the GA applicant or recipient, and forwarding the form to the social security administration;

(8) tracking payments to providers of services to a GA applicant or recipient.

C. Determining good cause: The case manager shall determine good cause for the failure of an applicant or recipient to comply with the GA application process, a contingency requirement, or any other condition of eligibility. The case manager shall notify the IRU of any refusal or failure by the GA recipient to comply with a condition of eligibility, a contingency requirement, or a referral for treatment or rehabilitative services.

D. Audit of time-limited determinations: Case managers shall be responsible for auditing, on an informal basis, a sample of time-limited disability determinations. Case managers will work with caseworkers in local ISD offices to gather necessary documentation to support or otherwise complete the determination. A determination that the medical documentation does not exist shall result in termination of cash assistance in the month following the month in which the notice of adverse action expires.

[8.106.420.16 NMAC - N, 07/01/2004]

8.106.420.17 RESPONSIBILITY FOR DETERMINATION OF ELIGIBILITY - INCAPACITY REVIEW UNIT (IRU):

A. The IRU:

(1) has the sole responsibility for reviewing medical reports and medical documentation to determine the disability of an applicant or recipient of temporary or permanent GA;

(2) shall work with the DPU to complete an application or medical review when the disability is temporary or permanent;

(3) is responsible for determining

whether a disability is temporary or permanent;

(4) is responsible for determining the duration of the disability, i.e., that an impairment is of a temporary duration of six months or longer, or a permanent impairment lasting 12 months or more;

(5) whether minimal employment affects the disability determination.

B. Contingency requirements: The IRU is responsible for determining whether an individual must meet a contingency requirement as a condition of eligibility for GA.

C. Reevaluation of disability: The IRU determination shall included, but may not be limited to:

(1) whether a GA recipient's disability must be reevaluated;

(2) the next review date for reevaluation;

(3) whether there is a need for current, updated medical reports to update the medical condition;

(4) whether there are any changes in work-related factors;

(5) whether a disability is still of a permanent or temporary nature; or

(6) whether a disability still exists.

D. For a GA disability determined to last six months or longer, or a permanent disability lasting 12 months or more, the IRU shall make the determination whether the disability and/or the duration can be extended beyond the initial six month certification period.

E. The IRU shall not be responsible for determining eligibility on any factor other than disability.

[8.106.420.17 NMAC - N, 07/01/2004]

8.106.420.18 CONDITIONS OF ELIGIBILITY - TEMPORARY OR PERMANENT DISABILITY

A. Employment of applicant/recipient: A GA applicant's or recipient's employment shall be taken into consideration in determining disability based on the type of employment, the duration of the employment, and verification that the employment is minimal.

(1) Minimal employment: An individual who is minimally employed may still be considered disabled if the individual cannot reasonably be expected to be self-supporting by at least the standard of need for the size of the benefit group.

(2) Shelter work: Work made available to an individual through the interest or compassion of others, or to rehabilitate an individual (as in a sheltered workshop), but which would not ordinarily exist on the open labor market, shall not be considered employment in a disability determination.

B. SSI status for GA-disabled adults:

(1) Any individual who is potentially eligible for SSI on the basis of either age or disability must apply for and accept SSI if approved by the social security administration.

(2) Ongoing SSI: An individual receiving SSI, or who would be receiving SSI except for recovery of an overpayment by the social security administration, is not eligible for GA.

C. SSI application requirement for disabled individuals:

(1) An individual who is approved for GA based on a temporary or permanent disability must file an application for SSI or OASDI within 60 days following approval. The GA recipient must follow through with the SSI application process and maintain an active SSI or OASDI application.

(2) An individual whose SSI or OASDI application has been denied or terminated must request and pursue his right to a hearing and appeal through the administrative law judge (ALJ) appeal level of the social security administration (SSA). If an individual has allowed his or her hearing rights to expire, the individual must file a new application with the SSA.

(3) An individual who has pursued his or her hearing rights through the SSA and who has not been approved shall not be required to pursue SSI or OASDI benefits any further, unless the IRU determines that there has been an increase in the individual's disability.

(4) A GA recipient who has not applied for SSI by the end of the month in which the 60th day occurs shall be ineligible to continue receiving GA. In such a situation, a notice of adverse action must be issued. If the individual files an application for OASDI and/or SSI by the end of the month in which the notice of adverse action expires, the individual's benefits will be reinstated.

D. Contingency requirements: To remain eligible for GA, an individual must accept corrective treatment available outside the GA program, unless a determination is made that good cause exists for the individual's inability to comply.

(1) The GA recipient shall be informed of any ongoing conditions or contingency requirements that must be met in order to ensure ongoing eligibility.

(2) To remain eligible, an individual must accept corrective treatment and comply with contingency requirements for continued eligibility.

(3) If appropriate, the individual shall be referred to the division of vocational rehabilitation (DVR). A recipient must accept vocational rehabilitation services if offered by DVR.

(4) The IRU shall make a determination of whether a contingency requirement is warranted and must be met to maintain eligibility for GA.

(5) The IRU shall not impose a time limit or deadline for a contingency requirement to be met that cannot realistically be met in the community in which the GA recipient resides.

(6) If a recipient of GA fails or refuses a referral, treatment or rehabilitation services, the case shall be reviewed by the DPU and/or IRU to determine if the refusal was for good cause. A determination that the failure or refusal to accept corrective treatment was for good cause will not result in termination of benefits. A determination that the failure or refusal was not for a good cause reason shall result in termination of GA benefits.

E. Good cause: Good cause is determined on an individual basis. There may be situations in which good cause exists for a GA recipient's inability to comply with a contingency requirement, including but not limited to:

(1) treatment that involves more than reasonable risk to correct the impairment;

(2) treatment that conflicts with the individual's sincere religious beliefs;

(3) fear of additional treatment that could interfere with or reduce the benefits of current treatment interventions;

(4) treatment that may cause further limitations or loss of a function or organ and the recipient is not willing to take the risk;

(5) the treatment is not available without cost or minimal cost to the recipient;

(6) the treatment is totally unavailable or not available at the frequency required due to lack of providers in the project area in which the recipient resides;

(7) the failure of ISD to provide written notice or sufficient information to the recipient about the contingency requirement;

(8) the recipient's inability to participate because of documented barriers, such as lack of transportation, an inability to leave work, illness, or death in the immediate family;

(9) the contingency requirement was made in error;

(10) a good cause reason approved by the IRU.

F. Change from time-limited to temporary or permanent GA disability:

(1) An individual who is receiving GA for a time-limited disability and is subsequently determined by the IRU to

have a temporary or permanent disability does not become ineligible if the individual has not filed an application for SSI or OASDI.

(a) The individual must file an application for, or otherwise verify that, an application has been filed for OASDI and/or SSI within 30 days of the IRU determination date.

(b) Failure to apply for SSI and/or OASDI within the 30-day limit makes the individual ineligible with respect to the SSI denial requirement.

(c) An individual who re-applies for GA after having been terminated for failure to apply for SSI and/or OASDI must apply for SSI and/or OASDI prior to or during the GA re-application process. Failure to apply for SSI and/or OASDI shall result in denial of the GA application on the 60th day after the date of application.

(2) Once the SSI denial requirement has been met, individuals classified as having a temporary or permanent disability must maintain an active application for SSI and/or OASDI. If the application for SSI and/or OASDI is denied, the individual must pursue the individual's hearing rights through the SSA. If the individual's hearing rights have expired, the individual must file a new application for SSI and/or OASDI.

(3) An individual who has pursued his or her hearing rights through the SSA and who has not been approved shall not be required to pursue SSI or OASDI benefits any further, unless the IRU determines that there has been an increased level of severity in the individual's disability.

G. Eligibility after the initial six-month certification: A GA recipient shall be required to comply with ongoing eligibility requirements after an initial six-month certification period has been assigned based on a temporary or permanent disability, including, but not limited to, attending medical or mental health appointments, providing additional information or verification, compliance with contingency requirements set by the DPU or IRU, or complying with a condition of eligibility. The GA recipient shall be responsible for verifying that good cause exists for his or her failure to comply.

[8.106.420.18 NMAC - N, 07/01/2004]

8.106.420.19 CONDITION OF ELIGIBILITY - INTERIM ASSISTANCE REIMBURSEMENT:

A. The state of New Mexico is a participant in the interim assistance reimbursement (IAR) program administered by the social security administration (SSA). The U.S. secretary of health and human services, through the SSA, has agreed to reimburse the state through HSD for general assistance payments made to an individual receiving GA disability during the period the individual's application for SSI was pending. Upon approval of SSI, SSA sends the first retroactive SSI payment due an individual to HSD as repayment for the state-funded GA payments made to the individual. The repayment of GA benefits from SSI is referred to as interim assistance reimbursement (IAR).

B. Interim assistance authorization: An individual applying for GA based on a time-limited, temporary or permanent disability must, as a condition of eligibility, authorize in writing the reimbursement to HSD for the amount of GA benefits paid on the individual's behalf for any month in which the SSA pays retroactive benefits to the individual.

(1) Completing the IAR authorization: The IAR authorization shall be completed and signed by the applicant at the time the individual is interviewed. Refusal to sign an IAR authorization shall result in immediate denial of a GA application.

(2) The completed and signed IAR authorization form shall be forwarded to the SSA by the disability processing unit.

(3) Duration of authorization: The authorization for IAR shall remain in effect from the date of signature until:

(a) SSA releases the SSI retroactive payment to HSD and HSD recovers the full amount to which it is entitled; or

(b) HSD and the individual agree to terminate the authorization.

(4) Termination of GA benefits does not constitute termination of the IAR authorization. HSD shall receive the first retroactive SSI payment for an individual who has received GA in the past and for whom an IAR authorization is in effect.

C. Validity of an IAR authorization: In order for the IAR authorization to remain in effect, an individual must have filed an application for SSI within 12 months of signing the authorization.

D. GA benefits shall be terminated when a determination is made that an individual has failed or refused to follow through with the initial SSI application interview, or failed or refused to file a timely request for reconsideration or appeal of an SSI denial.

E. Determination of repayment amount:

(1) The amount of repayment of GA benefits from SSI shall be determined by comparing the months and amounts of GA paid to the individual to the months and amounts of the SSI retroactive payment issued by the SSA. The amount available for reimbursement to the department shall be calculated from the first day the individual is eligible for SSI benefits and shall end with (and include) the month the retroactive SSI payment is made.

(2) For each month that GA and SSI were both paid, the department shall recoup the amount of the GA benefit, not to exceed the amount of SSI for that month.

(3) The department shall not recoup an SSI payment for any month in which a GA payment was not issued.

(4) Emergency advance SSI payments shall not be available for recoupment. Presumptive disability SSI payments shall not be available for recoupment.

F. Issuance of balance of SSI payment: When the amount of the total SSI payment exceeds the total GA payment, the balance of the remaining SSI retroactive payment(s) shall be sent to the individual within 10 calendar days of the date the department received the SSI retroactive payment from SSA. The balance shall be paid in the form of an HSD warrant. The individual shall be informed in writing of the retroactive SSI payment amount, how the repayment amount was computed by the department, and the balance being sent to the individual.

G. Returned checks: When the department is issued an amount greater than the amount of GA benefits paid to an individual, and the excess payment cannot be issued because the individual is deceased or cannot be located, the balance of the SSI retroactive payment shall be returned to SSA.

H. When the individual dies before eligibility is determined: The department has the right to receive repayment for GA benefits paid to an individual who dies before a determination of SSI eligibility is made. In such a circumstance, SSA will make a determination of eligibility or ineligibility for payment. Any excess payment after recovery by HSD will be returned to SSA.

[8.106.420.19 NMAC - N, 07/01/2004]

History of 8.106.420 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 430 RECIPIENT POLICIES - REQUIREMENTS FOR DEPENDENT CHILDREN

8.106.430.1 ISSUING AGENCY: New Mexico Human Services Department.

[8.106.430.1 NMAC - N, 07/01/2004]

8.106.430.2 SCOPE: The rule applies to the general public.

[8.106.430.2 NMAC - N, 07/01/2004]

8.106.430.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.
[8.106.430.3 NMAC - N, 07/01/2004]

8.106.430.4 DURATION: Permanent.
[8.106.430.4 NMAC - N, 07/01/2004]

8.106.430.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.106.430.5 NMAC - N, 07/01/2004]

8.106.430.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low income individual at the time of death.
[8.106.430.6 NMAC - N, 07/01/2004]

8.106.430.7 DEFINITIONS: [Reserved]
[8.106.430.7 NMAC - N, 07/01/2004]

8.106.430.8 AGE - DEPENDENT CHILDREN: To be eligible for inclusion in the GA dependent child benefit group with respect to age, a dependent child is defined as an individual who is;

A. seventeen years of age or younger;

B. eighteen years of age and enrolled in high school; or

C. between eighteen and twenty-two years of age and receiving special education services regulated by the public education department (PED).
[8.106.430.8 NMAC - N, 07/01/2004]

8.106.430.9 SCHOOL ATTENDANCE

A. Requirement for unrelated dependent children: The school attendance requirement applies to unrelated dependent children included in the benefit group.

(1) A dependent child age six through age seventeen must be a full-time student at a certified educational facility or participating and fully complying with a home-schooling program approved by the public education department.

(2) An individual who is age eighteen may be included in the GA benefit group if the individual is enrolled in and attending high school, a GED program or the high school equivalent level of vocational or technical training. Such an individual may be eligible to be included in the GA benefit group until the end of the month in which the individual graduates or until the end of the month in which the individual turns nineteen, whichever occurs first.

(3) A student who is age 18 and under age 22 may be included in the GA benefit group as long as the student is enrolled in high school and is receiving special education services regulated by the public education department. There must be a current and valid individual education plan (IEP) for the student to verify the special education services.

(4) A dependent child age seventeen or younger, who has graduated from high school or has obtained a GED, shall be deemed to be a full-time student and to be fulfilling attendance requirements until the month before the individual turns eighteen.

(5) The caretaker of an unrelated dependent child who is participating in a home-schooling program must provide a certification from the public school system that a home-schooling curriculum has been approved for the dependent child. The certification must be submitted at the beginning of each school year or when a home-schooling program begins.

(6) Minor unmarried pregnant woman: To be eligible for inclusion in the GA benefit group, an minor unmarried pregnant woman must attend school full time to obtain a high school diploma, participate in a GED program full time, or must participate in an approved alternative schooling program unless the minor unmarried pregnant woman has already graduated from high school or obtained a GED.

B. Full-time attendance:

(1) Whether a child is considered a full-time student and meeting full-time attendance requirements is based on the standards of the educational facility or program in which the child is enrolled.

(2) Vacations and other interruptions: A child enrolled in and attending classes is considered in attendance during:

(a) regularly scheduled vacations and breaks, including summer vacation, provided that:

(i) the child has not been removed for non-attendance; and

(ii) the child resumes attendance when classes start again;

(b) periods of personal illness or convalescence;

(c) family emergencies, for a period not to exceed 30 days;

(d) participation in, or attendance at, cultural and religious activities as long as the child has consent of the caretaker.

C. Determining whether the school attendance requirement is met:

(1) The school attendance requirement is not applicable during the initial application process. For purposes of the school attendance requirement, an initial application is defined as a new application for assistance when:

(a) an applicant has never been known to ISD;

(b) an application to add a new member to the benefit group who has never been known to ISD; or

(c) an application is for an individual or case that has been closed for six months or more.

(2) If a child has failed to comply with school attendance requirements, the child's needs shall be removed from the benefit group's standard of need if the child:

(a) is not enrolled in school;

(b) has accumulated three unexcused absences in a grading period, but not on the same day;

(c) has dropped out of school during the current grading period; or

(d) has completed a school attendance plan and has one or more unexcused absences during the time period covered by the plan.

(3) School attendance verification: The caseworker shall verify school attendance for school days occurring after the initial GA application has been approved. Verification of school attendance is mandatory at each certification, or when the caseworker becomes aware that the child may not be in compliance with school attendance requirements.

D. Caretaker's reporting responsibility: Within fourteen days of the date it becomes known to the caretaker, the caretaker must report to ISD if a child is not enrolled in school, has accumulated three unexcused absences during the current grading period, or has dropped out of school. Failure to report that a child has not met school attendance requirements shall result in conciliation and removal of the child's needs from the benefit group's standard of need, if appropriate. The GA payment shall not be reduced because of the failure of a caretaker, who is not included in the GA benefit group, to report that a

dependent child failed to attend school.

E. Failure to comply with school attendance requirements:

(1) Conciliation: Prior to removing the child's needs from the benefit group's standard of need, the caretaker shall be allowed a compliance period to address school non-attendance.

(a) The compliance period is ten working days, beginning with the date of issuance of the notice to provide a school attendance plan affording an opportunity for the caretaker, the child, and the school to develop a plan to ensure regular attendance by the child.

(b) If the school confirms that satisfactory arrangements have been made to ensure regular attendance by the child, the child shall remain eligible.

(c) A verified GED or home-schooling program may serve to show that a satisfactory school attendance plan has been established.

(d) School attendance plan: The school attendance plan must be signed by both the caretaker and an appropriate employee of the school, such as a counselor or principal. The school attendance plan shall contain specific requirements that the student must meet to comply with GA school attendance requirements.

(2) Conciliation process:

(a) Within 10 days of determining that a child has not met school attendance requirements, the caseworker shall take action to initiate a compliance period.

(b) A compliance period is initiated by the caseworker by issuing a notice of action to the benefit group.

(c) If the benefit group fails to provide a school attendance plan, a notice of adverse action shall be sent no earlier than the next working day after the expiration of the compliance period.

(3) Benefit reduction:

(a) The child shall be removed from the benefit group effective the month following the month in which the notice of adverse action expires.

(b) If there is one (or more) unexcused absence following successful submission of a school attendance plan, ISD shall remove the child's needs from the standard of need for the benefit group, effective the month following the month in which the adverse action notice expires.

(c) Case closure: If the child is the only child included in the benefit group, the cash assistance case shall be closed.

F. Regaining eligibility: Once a child has been removed from the benefit group due to failure to comply with school attendance requirements, the child cannot be considered a member of the benefit group until the child has attended school with no unexcused absences for a period of 30 calendar days.

(1) A child shall regain eligibility effective the month following the month in which the 30-day attendance requirement is met.

(2) A child may regain eligibility by attending summer school or its equivalent.

(3) A child may not regain eligibility by moving from one benefit group to another.

[8.106.430.9 NMAC - N, 07/01/2004]

8.106.430.10 CHILD SUPPORT ENFORCEMENT

A. Assignment of support rights: A caretaker who receives cash assistance for an unrelated dependent child, whether or not the caretaker is included in the benefit group, automatically assigns to HSD the right to child support for any individual included in the benefit group. The assignment shall be:

(1) effective with respect to any dependent child included in the benefit group;

(2) valid as long as the caretaker receives GA payments on the child's behalf; and

(3) includes any child support amount for which the caretaker is or may become eligible on behalf of any dependent child included in the benefit group.

B. Cooperation:

(1) The caretaker who is responsible for each child included in the benefit group must cooperate with the child support enforcement division (CSED) in obtaining child support. The caretaker shall be required to cooperate regardless of whether the caretaker is included in the benefit group.

(2) Failure to cooperate with a child support enforcement requirement will result in payment reduction through the sanction process.

(3) Failure to cooperate shall result in the personal ineligibility of the caretaker if the caretaker is included in the GA benefit group, and in a payment sanction against the benefit group, as described in 8.106.620.10 NMAC.

(4) The caretaker must turn over to CSED any child support payment which the caretaker receives directly from a non-custodial parent of the unrelated dependent child.

C. Determining that cooperation exists:

(1) A caretaker who signs an application or other applicable child support-related forms, on behalf of an unrelated dependent child indicates an understanding of the requirement to assign support rights to the department.

(2) The caretaker shall be considered to have met the cooperation requirement until such time as CSED reports to the caseworker that the caretaker has failed to cooperate.

(3) The determination whether the caretaker has cooperated with CSED shall be made by CSED based on CSED requirements.

(4) The cooperation requirement may be partially or fully waived by CSED upon demonstration of good cause by the caretaker.

D. Action upon receiving notice of noncompliance: Within ten days after notification by CSED of the failure of a caretaker to cooperate, the caseworker shall take action that is appropriate to the status of the case, including:

(1) issuing a conciliation notice that allows a period of time for the caretaker to cooperate and avoid payment reduction ; or

(2) removing the needs of the dependent child from the cash assistance payment; and

(3) imposing a noncompliance sanction, in cases where the caretaker is included in the benefit group;

(4) in a cases where the dependent child is the only benefit group member, GA benefits shall be terminated upon a determination that the caretaker has failed to cooperate with the assignment of rights to child support.

E. Good cause:

(1) In some situations, it is not in the best interests of the child or caretaker to pursue support or to require that the caretaker cooperate with CSED in pursuing such support. A caretaker shall be:

(a) notified that the requirement to cooperate may be waived,

(b) informed of the requirements involved in the waiver, and

(c) given an opportunity to request a waiver that would exempt the caretaker from the cooperation requirement.

(2) If a caretaker requests a waiver of the cooperation requirement, assistance shall not be delayed pending determination of good cause, nor may enforcement of support begin or continue while the waiver of the requirement is under consideration.

(3) Granting a good cause exemption: The decision whether to grant a good cause exemption shall be made according to the following:

(a) ISD-domestic violence exemption: ISD shall exempt a caretaker from CSED cooperation requirements where a trained counselor, such as a domestic violence counselor or social worker, has certified that cooperation would make it more difficult to escape a domestic violence situation involving a parent of the dependent child, or would unfairly penalize the

caretaker or child in light of current circumstances.

(b) CSED-other good cause exemptions: All other good cause exemptions from cooperation with CSED requirements shall be made by the director of the CSED or designee.

(4) Notification: The caseworker shall send a caretaker a written notice when a waiver has been granted due to domestic violence.

(a) The caretaker shall be informed whether CSED has determined that support can be pursued without danger or risk to the caretaker or child. If pursuit is planned, the caretaker shall be notified that he or she must cooperate to the extent of providing necessary information and documents and that, if the caretaker does not comply to the extent possible, a noncompliance sanction will be imposed or benefits will be terminated.

(b) A caretaker shall be notified of the right to a fair hearing, and that the caretaker may ask for such a hearing within 90 days of the date on the written notice.

(c) If CSED determines that good cause does not exist, the caseworker shall notify the caretaker within 10 working days that:

(i) the request has been denied;

(ii) the caretaker is expected to cooperate fully in pursuing support; and

(iii) the caretaker may request an administrative hearing, but that the caretaker is expected to begin cooperating within ten days after the date of the notice.

[8.106.430.10 NMAC - N, 07/01/2004]

History of 8.106.430 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 500 ELIGIBILITY POLICY - GENERAL INFORMATION

8.106.500.1 ISSUING AGENCY: New Mexico Human Services Department.
[8.106.500.1 NMAC - N, 07/01/2004]

8.106.500.2 SCOPE: The rule applies to the general public.
[8.106.500.2 NMAC - N, 07/01/2004]

8.106.500.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.
[8.106.500.3 NMAC - N, 07/01/2004]

8.106.500.4 DURATION: Permanent.
[8.106.500.4 NMAC - N, 07/01/2004]

8.106.500.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.106.500.5 NMAC - N, 07/01/2004]

8.106.500.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI). The general assistance program is not intended to be an unemployment or general relief program.

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low-income individual at the time of death.
[8.106.500.6 NMAC - N, 07/01/2004]

8.106.500.7 DEFINITIONS: [Reserved]
[8.106.500.7 NMAC - N, 07/01/2004]

8.106.500.8 GA - GENERAL REQUIREMENTS:

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

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

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

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

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

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

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

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

(a) one person $ 637
(b) two persons $ 859
(c) three persons $1,081
(d) four persons $1,304
(e) five persons $1,526
(f) six persons $1,748
(g) seven persons $1,971
(h) eight persons $2,193
(i) nine persons $2,416
(j) ten persons $2,638
(k) for more than ten persons, add $223 for each additional person.

D. Standard of need:

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

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

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

(4) The standard of need for the GA cash assistance benefit group is:

(a) one person $ 231
(b) two persons 310
(c) three persons 389
(d) four persons 469
(e) five persons 548
(f) six persons 627
(g) seven persons 706
(h) eight persons 802
(i) nine persons 881
(j) ten persons 960
(k) for more than 10 persons, add $79 for each additional person.

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

F. Special clothing allowance for school-age dependent children: In order to assist in preparing a child for school, a special clothing allowance is made each year in the amount of $44 for the month of August only.

(1) For purposes of determining eligibility for the clothing allowance, a

child is considered to be of school age if the child is six years of age or older and less than age nineteen (19) by the end of August.

(2) The clothing allowance shall be allowed for each school-age child who is included in the GA cash assistance benefit group for the month of August.

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

[8.106.500.8 NMAC - N, 07/01/2004]

8.106.500.9 PROSPECTIVE BUDGETING

A. Initial eligibility: Eligibility for cash assistance programs shall be determined prospectively. The benefit group must meet all eligibility criteria in the month following the month of application. Eligibility and amount of payment shall be determined prospectively for each month in the certification period.

B. Changes in benefit group composition: A person added to the benefit group shall have eligibility determined prospectively, beginning in the month following the month the report is made.

C. Anticipating income: In determining the benefit group's eligibility and benefit amount, the income already received and any income the benefit group expects to receive during the certification period shall be counted.

(1) Income anticipated during the certification period shall be counted only in the month it is expected to be received, unless the income is averaged.

(2) Actual income shall be calculated by using the income already received and any other income that can reasonably be anticipated in the calendar month.

(3) If the amount of income or date of receipt is uncertain, the portion of the income that is uncertain shall not be counted.

(4) In cases where the receipt of income is reasonably certain but the amount may fluctuate, the income shall be averaged.

(5) Averaging is used to determine a monthly calculation, when there is fluctuating income within the weekly, biweekly or monthly pay period and to achieve a uniform amount for projecting future income.

D. Counting income in the certification period:

(1) For the purposes of cash assistance eligibility and determination of benefit amount, income is money received by or available to the benefit group in each month of the certification period.

(2) Only income which is actually received, or can reasonably be expected to be received, is counted for financial eligibility and benefit calculation.

(3) The benefit group must take appropriate steps to apply for and receive income from any other source to which the group may potentially be entitled.

(4) A benefit group may be found ineligible for failing or refusing to apply for or pursue potential income or assets from other sources.

(5) A benefit group member who is 62 years of age or older must apply for and take all necessary steps to receive a reduced OASDI benefit from the SSA.

E. Income availability:

(1) The availability of income to the benefit group is determined by who must be included in the benefit group and whether income must be deemed available to the benefit group.

(2) The earned and unearned income of an individual who is not a mandatory benefit group member shall not be considered available to the benefit group.

(3) Income belongs to the person who gains it, either through the person's own efforts, as in the case of earnings, or as a benefit, as in the case of a beneficiary of SSA benefits.

(4) Unearned income, such as child support or social security survivor's benefits and other similar payments for a child, are considered as belonging to the benefit group in which the child is included.

(5) Alien sponsors: The gross income belonging to an individual who is the sponsor of an alien included in the cash assistance benefit group, and the income belonging to the sponsor's spouse, shall be counted in its entirety to determine the eligibility and benefit amount if the sponsor has executed an affidavit of support pursuant to Subsection 213-A of the Immigration and Nationality Act. The income of the alien sponsor and spouse shall be counted until the sponsored alien achieves citizenship or can be credited with 40 qualifying quarters under title II of the federal Social Security Act.

F. Unavailable income: In some situations, individuals who are included in the benefit group, either in applicant or recipient status, have a legal right to income but do not have access to it. Such income is not counted as available income for purposes of cash assistance eligibility and benefit calculation.

G. Ineligible alien: The countable income belonging to an ineligible alien who is a mandatory benefit group member is deemed available to the benefit group. The countable income shall be prorated according to the size of the benefit group to determine the eligibility and benefit amount for the benefit group.

H. Income received less frequently than monthly: The amount of gross income that is received less frequently than monthly is determined by dividing the total gross income by the number of months the income is intended to cover. This includes, but is not limited to, income from sharecropping, farming and self-employment. It also includes contract income as well as income of a tenured teacher who may not actually have a contract.

I. Contract income: A benefit group that derives its annual income in a period of less than one year shall have that income averaged over a twelve-month period, provided that the income is not earned on an hourly or piecework basis.

J. Using exact income: Exact income, rather than averaged income, shall be used if:

(1) the benefit group has chosen not to average income;

(2) income is from a source terminated in the month of application;

(3) employment began in the application month and the income represents a partial month; or

(4) income is received more frequently than weekly.

K. Income projection for earned income:

(1) Income from the four-week period prior to the date of initial interview is used to project monthly income, provided that the income is expected to continue. If a determination is made that the prior income is not indicative of income anticipated to be received during the certification period, then income from a longer period of past time may be used. If the longer period is not indicative of income anticipated to be received, then verification of anticipated income shall be obtained from the income source.

(2) The methods described above may not give the most accurate estimate of monthly earnings due to unique circumstances that may occur. In such cases, the caseworker shall use whichever method provides the most accurate estimate of earnings.

(3) An income projection shall be considered valid for the certification period unless changes are made that affect eligibility or benefit amount.

L. Unearned income: For purposes of anticipating future income, unearned income from the four-week period prior to the date of interview shall be used, provided that the income is expected to continue.

M. Use of conversion factors: Conversion factors are used to adjust the monthly income amounts. For those months in which an extra weekly or biweekly paycheck is received, conversion factors are used to distribute the pay periods equal-

ly for the months in the certification period.

(1) Whenever a full month's income is anticipated, but is received on a weekly or biweekly basis, the income shall be converted to a monthly amount.

(2) Income received weekly is multiplied by 4.3.

(3) Income received biweekly is multiplied by 2.15.

N. Rounding of income when using conversion factors: Averaged income is rounded prior to application of the conversion factor. If the cents are $.49 or below, the cents are dropped. If the cents are $.50 or more, the amount is rounded up to the next higher dollar.

[8.106.500.9 NMAC - N, 07/01/2004]

8.106.500.10 PAYMENTS TO ADULTS IN RESIDENTIAL CARE

A. Conditions: Subject to the availability of state funding for the program, a payment may be made to an individual who resides in a shelter care home. The individual must be a recipient of supplemental security income (SSI) under title XVI of the Social Security Act.

B. Licensing of the shelter care home: The shelter care home must be licensed pursuant to regulations of the New Mexico department of health.

C. Payment: A cash payment may be made to an SSI recipient when the recipient resides in a licensed shelter care home because the recipient needs help with personal care, such as bathing, dressing, eating or taking prescribed medication.

(1) The payment shall be allowed only if the SSI recipient resides in a residential shelter care facility that is licensed by the New Mexico department of health.

(2) The payment made to an SSI recipient living in a licensed residential shelter care facility is $100 per month.

[8.106.500.10 NMAC - N, 07/01/2004]

8.106.500.11 BURIAL ASSISTANCE - FUNERAL EXPENSES

A. Eligibility: Payment towards the burial expenses for a categorically eligible individual may be made when the resources considered available to meet the cost of the funeral are less than $600. Resources that shall be considered available include:

(1) cash available to the deceased at the time of death;

(2) any insurance benefits designated for use in meeting the individual's funeral costs;

(3) any other death or burial benefits from sources such as social security or railroad retirement benefits, veterans benefits, legally responsible relatives or the estate of the deceased;

(4) gifts, contributions or written commitments to help pay the cost of the funeral, which are made by any individual not having a legal support obligation for the deceased.

B. Covered services: Funeral costs that are considered include necessary compulsory expenditures arising immediately upon and due to death, including:

(1) embalming;

(2) purchase of a coffin, burial shroud and burial plot;

(3) burial or cremation services, including the cost for opening and closing the grave;

(4) customary ceremonies, rites and services, excluding food, beverages or other similar consumables attendant on disposition of the remains; and

(5) transportation of the deceased from the mortuary to a nearby cemetery.

C. Payment: When resources are determined to be less than $600, a payment of up to $200 may be made towards the cost of the funeral. The amount of the payment is the difference between the cost of the funeral and available resources. The payment shall not exceed $200.

D. Payment procedures: Funeral payments are reimbursed by a payment voucher to the vendor providing the services.

[8.106.500.11 NMAC - N, 07/01/2004]

History of 8.106.500 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 510 ELIGIBILITY POLICY - RESOURCES/PROPERTY

8.106.510.1 ISSUING AGENCY: New Mexico Human Services Department.

[8.106.510.1 NMAC - N, 07/01/2004]

8.106.510.2 SCOPE: The rule applies to the general public.

[8.106.510.2 NMAC - N, 07/01/2004]

8.106.510.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

[8.106.510.3 NMAC - N, 07/01/2004]

8.106.510.4 DURATION: Permanent.

[8.106.510.4 NMAC - N, 07/01/2004]

8.106.510.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.

[8.106.510.5 NMAC- N, 07/01/2004]

8.106.510.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low-income individual at the time of death.

[8.106.510.6 NMAC - N, 07/01/2004]

8.106.510.7 DEFINITIONS: [Reserved]

[8.106.510.7 NMAC - N, 07/01/2004]

8.106.510.8 RESOURCE STANDARDS: To be eligible, the value of all countable personal and real property, belonging to or considered as belonging to or considered available to the benefit group, shall not exceed the liquid or non-liquid resource limits. Total resources that exceed the liquid or non-liquid resource limit result in benefit group ineligibility unless the nature of the property or an express condition of its ownership prohibits its transfer. Resources are evaluated based upon their equity value.

A. Liquid resources: The value of countable liquid resources shall not exceed $1,500.

B. Non-liquid resources: The value of countable non-liquid resources shall not exceed $2,000.

[8.106.510.8 NMAC - N, 07/01/2004]

8.106.510.9 COUNTABLE RESOURCES:

A. Non-liquid real property: means land and the structures (including mobile homes) and improvements affixed to it.

(1) The value of countable real property owned by or considered available to the benefit group, shall be considered in

determining whether non-liquid resources exceed $2,000.

(2) Grazing permits are considered to be real property.

B. Personal property (liquid or non-liquid): means all property, other than real property, and includes such possessions as bank accounts, cash (other than the current month's income), motor vehicles, livestock, tools, equipment and rights to receive money, such as stocks, bonds, contract rights, insurance policies, etc. The types of personal property that must be counted in determining whether the benefit group's resources exceed the resource limits include, but are not limited to:

(1) Life insurance:

(a) Life insurance policies owned by a member of the benefit group shall be considered as a resource that may be converted into cash. The cash value of the life insurance policy shall be counted toward the liquid resource limit.

(b) Information about lapsed insurance shall be obtained , since many lapsed policies have a cash value.

(2) Cash, bank accounts and other readily negotiable assets:

(a) Readily available cash, such as cash on hand or money in a bank account and other readily negotiable assets, shall be considered as a liquid resource and shall be counted toward the liquid resource limit.

(b) "Other readily negotiable assets" include stocks, bonds, negotiable notes, purchase contracts and other similar assets. For purposes of cash assistance eligibility, the value of such assets is their current market value.

(3) Motor vehicles, equipment and tools:

(a) The equity value of all motor vehicles, equipment and tools is countable, unless specifically excluded.

(b) The value of motor vehicles, equipment and tools, except as set forth in Paragraph 1 of Subsection B of 8.106.510.10 NMAC below, is subject to the non-liquid resource test.

(4) Asset conversion:

(a) Money received from one-time-only or sporadic sales of real or personal property, such as crops, rugs, jewelry, etc., shall be considered an asset, rather than income, provided that the property is not sold or transferred in connection with a business or self-employment activity.

(b) Assets converted into money are subject to the $1,500 liquid assets limitation, regardless of whether they were fully or partially exempt prior to conversion.

(5) Lump sum payments: Payments of a one-time nature, such as retroactive monthly payments, payments in the nature of a windfall, personal injury and worker's compensation awards, gambling winnings, etc., shall be considered a resource subject to the liquid resource limit. [8.106.510.9 NMAC - N, 07/01/2004]

8.106.510.10 RESOURCE EXCLUSIONS:

A. Real property:

(1) The home: The value of the benefit group's home is not considered in determining eligibility. The "home" is the dwelling place occupied by the benefit group. The home is considered to be occupied by the benefit group during a temporary absence, when there is a definite plan to return to the home and no one else is occupying it.

(2) "Home" includes, in addition to the residence building and the land upon which it is constructed, the following:

(a) a reasonable amount of land within reasonable proximity to the residence building, if that land is currently used by and useful to the client;

(b) outbuildings within reasonable proximity to the residence building, such as barn, garage and well, if the well is a principal source of water;

(c) buildings used for rental purposes, if located on land contiguous to the land upon which the residence building is constructed, and if these buildings cannot be divided from the residence land and sold separately;

(d) grazing permits currently being used to graze livestock owned by the client; and

(e) furniture, equipment and household goods necessary for the operation and maintenance of the home.

(3) Other real property - burial plots: One burial plot for each person included in the benefit group shall be excluded; a burial plot shall consist of the space needed to bury a member of the immediate family.

B. Exempt personal property: The value of the following items of personal property shall not be considered in determining eligibility for GA cash assistance:

(1) Vehicles: all vehicles used by the benefit group for transporting individuals to or from employment, for daily living activities, or for the transportation of goods shall be excluded from consideration as a resource subject to the non-liquid resource limit; recreational vehicles, such as boats or motor homes, shall not be excluded;

(2) Specially-equipped vehicles: a vehicle owned by the benefit group that is specially equipped for the handicapped shall not be considered in the determination of the liquid or non-liquid resource limit.

C. Exempt income: Any income that is exempt under income provisions is also exempt from consideration as a resource. To maintain its exempt status, exempt income that is accumulated must be kept separate from non-exempt savings.

D. Individual development account (IDA): Subject to the limitations set forth below, funds in an IDA are exempt from consideration as resources in determining benefit group eligibility. To be exempt from consideration, the IDA must be designated for a qualified purpose.

(1) Post-secondary education of a dependent child included in the benefit group: In order to be considered used for a qualified purpose, the post-secondary education funds must be paid from an IDA directly to an eligible education institution. For purposes of this regulation, post-secondary education expenses include:

(a) tuition and fees required for the enrollment or attendance of a student at an eligible education institution. An eligible institution is an institution described in section 481(a)(1) or 1201(a) of the Higher Education Act of 1965 (20 USC 1088(a)(1) or 1141(a)); an area vocational education school (as defined in section 521(4) of the Carl D. Perkins Vocational and Applied Technology Education Act (20 U.S.C. 2471(4)) located in any state; or

(b) books, fees, supplies and equipment required for courses of instruction at an eligible educational institution.

(2) Purchase of a principal residence for a first-time home buyer: The purpose of the IDA is to assist a qualified first-time home buyer to accumulate part of the cash necessary to initiate purchase of the individual's first home.

(a) Only IDA's established by qualified first-time home buyers shall be disregarded; a qualified first-time home buyer is one who has never had an ownership interest in a principal residence.

(b) The IDA may be used only for the purchase of a qualified principal residence; a qualified principal residence is one which qualifies as the principal home under subsection 1034 the federal internal revenue code, if the costs for which do not exceed 100% of the average area purchase price applicable to such residence, determined in accordance with paragraphs (2) and (3) of subsection 143(e) of the internal revenue code.

(c) No more than $1,500 may be accumulated in an IDA for first-time home purchase. Any amount in excess of $1,500 is considered in determining whether the benefit group meets the cash resource limit.

(3) Business capitalization: In order to be considered used for a qualified purpose, the funds have to be paid directly from the IDA to a business capitalization account established in a federally insured financial institution that is restricted to use

solely for qualified business capitalization expenses. A qualified business means any business that does not contravene any law or public policy. Qualified business capitalization expenses include capital, plant, equipment, working capital and inventory expenses. To be a qualified business, there must be a business plan which:

(a) is approved by a financial institution or a nonprofit loan fund having demonstrated fiduciary integrity;

(b) includes a description of services or goods to be sold, a marketing plan and projected financial statements; and

(c) may require the eligible individual to obtain the assistance of an experienced entrepreneurial advisor.

(4) To be disregarded, the IDA must meet the following requirements:

(a) the benefit group member must first establish and maintain a savings account with a balance of $1,500;

(b) the benefit group member must establish the IDA for one of the three purposes described above.

(c) in order for such accounts to be excludable, the IDA must be a trust created or organized in the United States, with trust language restricting use of account funds to the purposes as designated in this section; and

(d) the IDA must be funded exclusively with income earned by a benefit group member or by contributions made by a non-benefit group member.

(5) Funds withdrawn from the account and used for any purpose other than those specified under this section will cause the account to lose its status as an excluded resource, starting with the month in which the funds are withdrawn from the IDA account.

E. Funeral agreements: The equity value of funeral agreements owned by a benefit group member shall be excluded from consideration as a resource. Funeral agreements include any arrangement under which prepaid funeral services are provided or cash benefits that are intended to pay for funeral services are paid upon the individual's death. Such agreements include contracts with funeral homes, life or burial insurance, and trust or escrow accounts in financial institutions or banks, provided that the trust or escrow accounts contain provisions making the funds payable only upon the death of a named individual. There is no limit on the amount of the funeral agreement that can be disregarded.

F. Contingent or unliquidated claims: A "contingent or unliquidated claim" is an undetermined right of an individual to receive, at some future time, a resource such as an interest in an unprobated estate or damages or compensation resulting from an accident or injury. Such a claim is not considered a resource if the individual (either applicant or recipient) can demonstrate that an attorney has been consulted, or that under the circumstances, it is reasonable not to have consulted an attorney, and that the individual is making every reasonable effort to prosecute the claim or to proceed with the probate. If the individual can demonstrate that his or her share in an unprobated estate would be less than the expense of the proceedings to probate the estate, the value is not considered a resource.

G. Work-related equipment exclusion: Work-related equipment, such as the tools of a trades person or the machinery of a farmer, which are essential to the employment or self-employment of a benefit group member, are excluded, in an amount not to exceed $1,000 per individual, and remain excludable if the trades person becomes disabled. Farm machinery retains this exclusion for one year if the farmer ends self-employment.

H. Livestock: The value of livestock is an excluded non-liquid resource.

I. Federally excluded resources: Certain resources are excluded pursuant to federal law. For a listing of federally-excluded resources, see 8.139.527 NMAC.

[8.106.510.10 NMAC - N, 07/01/2004]

8.106.510.11 RESOURCE AVAILABILITY:

A. Availability: Resources that are actually available or that are considered to be available to the benefit group are considered in determining eligibility for assistance.

(1) The resource amount used for determination of eligibility for an applicant benefit group shall be based upon the status of the resources on the date of the application interview.

(2) The resource amount used for determination of eligibility for an active case shall be made based on the amount available in the month following the month of expiration of a notice of adverse action.

B. Potentially available resources: The benefit group is required to take all appropriate steps to make available to itself any liquid or non-liquid resource to which the group may be entitled but whose value is not currently considered available, e.g., an inheritance from an unprobated estate. The fact that specific property is not readily marketable on the client's terms is not a condition prohibiting transfer. The current value of property, which must be partitioned in order to be accessible, is not considered available if the net value (after estimated costs of partition and other closing costs) is less than the resource limit. If the amount likely to be derived from the applicant's/recipient's share of the property exceeds the resource limit, the applicant/recipient will be required to initiate attempts to obtain the applicant's/recipient's share of the estate.

C. Resources of benefit group members: A countable liquid or non-liquid resource that belongs to any member of the benefit group is considered available to the entire benefit group.

D. SSI recipients and other non-members: The property of individuals receiving SSI or that of other non-members shall not be considered available, regardless of relationship to benefit group members, except as indicated in Subsection F below.

E. Alien sponsor: The gross income and resources belonging to an individual who is the sponsor of an alien included in the cash assistance benefit group, and the income belonging to the sponsor's spouse, shall be counted in its entirety to determine the eligibility and payment amount if the sponsor has executed an affidavit of support pursuant to subsection 213-A of the Immigration and Nationality Act. The income and resources of the alien sponsor and spouse shall be counted until the sponsored alien achieves citizenship or can be credited with 40 qualifying quarters under title II of the federal Social Security Act.

F. Resources belonging to the unrelated caretaker: The liquid resources owned by an unrelated caretaker of a minor dependent child living in the home shall not be considered available to the child, unless the unrelated caretaker chooses to be included in the GA benefit group.

G. Jointly-owned resources: Resources owned jointly by the benefit group and any individual who is not a mandatory benefit group member shall be considered available in their entirety to the benefit group, unless it can be demonstrated by an applicant or recipient that such resources are inaccessible. The benefit group must verify that:

(1) it does not have the use of the resource;

(2) it did not make the purchase or down payment associated with the resource;

(3) it does not make the continuing loan payments; and

(4) the title is transferred to, or retained by, the other joint owner;

(5) if a benefit group can demonstrate that is has access to only a part of the resource, the value of that part is counted toward the benefit group's resource level; a resource will be considered totally inaccessible, if it cannot be practically subdivided

and the benefit group's access to the value of the resource is dependent on the agreement of a joint owner who refuses to comply; for purposes of this provision, ineligible aliens or disqualified individuals residing with a benefit group are considered benefit group members.

H. Joint bank accounts: If a bank account is owned jointly by a benefit group member and any other individual, the funds in the account are considered available to the benefit group to the extent that it has contributed to the account. If the participating benefit group has not contributed to the account, the funds are considered available only if there is clear and convincing evidence that the other joint owner of the account intends for the participating benefit group to have access to the funds.

[8.106.510.11 NMAC - N, 07/01/2004]

8.106.510.12 ELIGIBILITY DETERMINATION:

A. Determination: If, after determining what property is available to the benefit group and determining the value of that resource, the net value of the countable real and personal property exceeds resource limits, the benefit group shall be ineligible for assistance on the basis of need. The benefit group shall remain ineligible on the basis of need for as long as the value of the property exceeds the resource standards.

B. Receipt of resources: Resources acquired by a benefit group member after approval of an assistance grant shall be evaluated for purposes of financial assistance eligibility at the time of the change. Reporting requirements as indicated in Subsection D of 8.102.630.8 NMAC apply. If the benefit group becomes ineligible due to ownership or availability of resources, assistance is terminated effective the month following the month in which the notice of adverse action expires.

[8.106.510.12 NMAC - N, 07/01/2004]

8.106.510.13 NON-TRANSFER OF REAL PROPERTY:

A. Requirement:

(1) In order to include an individual in the benefit group, the individual must not have transferred real property for the purpose of becoming eligible for cash assistance within the two-year period preceding the date of application.

(2) A transfer is considered to be for the purpose of becoming eligible for cash assistance if:

(a) the transfer was made without a reasonable return; and

(b) the individual had no reasonable plan for support at the time of the transfer other than assistance from the department.

B. Transfer:

(1) For the purpose of this provision, transfer includes the sale, conveyance by deed, or any other method of transferring the title to the property involved, including transfer by gift. The transfer may be for either the title to the real property or other interests or rights in the property, such as mineral or water rights.

(2) A child under the age of 18 cannot transfer property, except through a legal guardian. Normally, a child will not own property in the child's own right, but if facts indicate the existence of a trust, inheritance or prior gifts to the child, it must be determined whether a transfer has taken place within the two-year period.

C. Reasonable return: A reasonable return on the transfer of property is considered to have been received when the person who made the transfer received compensation in cash or in kind equal to the value of the property at the time of transfer. The determination as to whether a reasonable return was received is based on the individual's equity interest in the property at the time of the transfer.

(1) Equity less than $2,000: If the value of the equity interest, plus all other countable resources, was less than $2,000, the transfer is not considered to be for the purpose of becoming eligible for cash assistance.

(2) Reasonable value not received: If it is determined that the property was transferred for the purpose of becoming eligible, but the client has subsequently made efforts to obtain a reasonable return or to regain title, and is willing to continue such efforts, eligibility on this condition exists. If the client is not willing to pursue a reasonable return, or to attempt to regain title to the property, the benefit group shall not be eligible for six months from the month ISD makes the determination that the transfer was made.

[8.106.510.13 NMAC - N, 07/01/2004]

History of 8.106.510 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 520 ELIGIBILITY POLICY - INCOME

8.106.520.1 ISSUING AGENCY: New Mexico Human Services Department.

[8.106.520.1 NMAC - N, 07/01/2004]

8.106.520.2 SCOPE: The rule applies to the general public.

[8.106.520.2 NMAC - N, 07/01/2004]

8.106.520.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

[8.106.520.3 NMAC - N, 07/01/2004]

8.106.520.4 DURATION: Permanent.

[8.106.520.4 NMAC - N, 07/01/2004]

8.106.520.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.

[8.106.520.5 NMAC - N, 07/01/2004]

8.106.520.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low-income individual at the time of death.

[8.106.520.6 NMAC - N, 07/01/2004]

8.106.520.7 DEFINITIONS: [Reserved]

[8.106.520.7 NMAC - N, 07/01/2004]

8.106.520.8 GENERAL

A. Income eligibility: To be eligible for GA cash assistance based on income the countable gross earned and unearned income available to the benefit group is considered to determine the income eligibility of the benefit group.

B. Gross income test: For the benefit group to be income eligible, the countable gross earned and unearned income considered available to the benefit group cannot exceed eighty-five percent (85%) of the federal poverty guidelines for the size of the benefit group.

C. Net income test: For the benefit group to be income eligible, the countable net income after all allowable

deductions must be less than the standard of need for the size of the benefit group.
[8.106.520.8 NMAC - N, 07/01/2004]

8.106.520.9 EXEMPT INCOME: The following income sources or assistance types are not considered available for the gross income test, the net income test and the cash payment calculation:

A. medicaid;

B. food stamp benefits;

C. government-subsidized foster care, if the child for whom the payment is received is not included in the benefit group;

D. SSI;

E. government-subsidized housing or housing payment; government includes any federal, state, local or tribal government, or a private non-profit or for-profit entity operating housing programs or using government funds to provide subsidized housing or to make housing payments.

F. income excluded by federal law (described in 8.139.527 NMAC);

G. educational payments made directly to an educational institution;

H. government-subsidized child care;

I. earned income that belongs to a child 17 years of age or younger who is not the head of household; only earned income paid directly to the child is considered as belonging to the child;

J. up to fifty dollars ($50.00) of collected child support passed through to the benefit group by the CSED;

K. an emergency one-time only payment made by other agencies or programs;

L. reimbursements for past or future identified expenses, to the extent they do not exceed actual expenses and do not represent a gain or benefit to the benefit group, such as expenses for job or job training-related activities, travel, per diem, uniforms, transportation costs to and from the job or training site, medical or dependent care reimbursements and any reimbursement for expenses incurred while participating in NMW work program activities; reimbursements for normal living expenses, such as rent, mortgage, clothing or food eaten at home are not excluded;

M. utility assistance payments, such as from LIHEAP, LITAP or similar assistance programs.
[8.106.520.9 NMAC - N, 07/01/2004]

8.106.520.10 EARNED INCOME DEFINITION:

A. Earned income means cash or payment in kind that is received as wages from employment, payment in lieu of wages, earnings from self-employment or earnings acquired from the direct provision of services, goods or property, production of goods, management of property or supervision of services.

B. Earnings include gross profit from self-employment, which requires substantial effort on a continuous basis by the individual who is receiving the income.

(1) Income from rental property is considered earnings if the individual regularly does painting, plumbing, carpentry, maintenance, cleaning or repair work on the property, or if substantial time is spent each month in bookkeeping, collecting rent, or paying bills on the property.

(2) Income from livestock is considered earnings if the individual raises livestock for the purpose of making cash sales. Net income received from the sale of livestock shall be considered in determining the cash assistance benefit amount.

(a) The income received from the sale of livestock may be prorated and projected on a monthly basis over the certification period.

(b) Domestic pets (cats, dogs, etc.) are not considered livestock, and their value is not considered in determining income eligibility, except when they are bred and raised for sale.

C. The use of property, such as inhabiting a home or apartment, is considered as earnings if it is received in exchange for services provided to the person owning or controlling the property, and the applicant or recipient would be legally obligated to make a payment for use of the property.
[8.106.520.10 NMAC - N, 07/01/2004]

8.106.520.11 DETERMINING INCOME FOR SELF-EMPLOYED INDIVIDUALS:

A. Reporting of earnings as business or self-employment income to state or federal tax authorities is the usual indicator of business or self-employment income. Criteria for verification of business and self-employment income are set forth in Paragraph 2 of Subsection B of 8.100.130.14 NMAC.

(1) Tax returns from the previous year may be used, unless the amount of business and self-employment income reported on tax returns is no longer a good indicator of anticipated income.

(2) If the self-employment enterprise has been in operation for such a short time that there is insufficient information to make a reasonable projection, the benefit group shall be required to report income at shorter intervals until there is enough information to make a longer projection of anticipated income.

(3) When tax forms are used to annualize and project income, the expenses reported on the tax forms shall be used, allowing for adjustments for those expenses or costs that are treated differently or not allowed under cash assistance policy.

(4) Capital gains are counted in full as income to determine self-employment income. A capital gain is defined as proceeds from the sale of capital goods or equipment.

B. Averaging business or self-employment income: Business or self-employment income is averaged over the period the income is intended to cover, even if the benefit group receives income from other sources.

(1) An individual in a benefit group, who by contract or self-employment derives his or her annual income in a period of time shorter than one year, must have income averaged over a twelve-month period.

(2) If significant changes have occurred because of a substantial increase or decrease in business and averaged income will not accurately reflect the self-employed individuals' income, the self-employment income shall be calculated on the basis of anticipated, not prior, earnings.

(3) If a self-employment enterprise has been in existence for less than one year, the income from self-employment shall be averaged over the period of time the business has been in operation. The resulting monthly amount shall be projected for the coming year.

(4) Seasonal income: Self-employment income that is intended to meet the benefit group's needs for only part of the year shall be averaged over the period of time the income is intended to cover.

C. Determining monthly business or self-employment income: For the period of time over which self-employment income is averaged, the individual's monthly self-employment income is determined by adding all self-employment income, including capital gains, and excluding allowable costs of producing the self-employment income, and dividing the resulting self-employment income by the number of months the income is intended to cover.
[8.106.520.11 NMAC - N, 07/01/2004]

8.106.520.12 EARNED INCOME DEDUCTIONS

A. Earnings deductions: Deductions from gross earned income shall be made in determining the net countable earned income of benefit group members.

(1) Earned income deductions may not exceed the amount of an individual's gross earned income.

(2) The earned income deductions may not be used to reduce unearned income, nor may deductions that are not used by one benefit group member be allocated against the earnings of another benefit group member.

(3) An allowable business expense or cost of producing self-employment income that has been used as a deduction from self-employment income shall not also be allowed as an earned income deduction.

B. Business expenses and self-employment costs: Business expenses and self-employment costs shall be deducted from the gross earnings of a self-employed benefit group member. The income remaining after all allowable business expenses and self-employment costs have been deducted shall be counted as the gross income of the benefit group member. To be eligible for a business or self-employment expense deduction, a Tax ID shall be required.

(1) Allowable expenses and costs: Allowable costs of producing self-employment income include, but are not limited to:

(a) costs of materials and supplies;

(b) business travel, but not personal commuting expenses, calculated at $.25 per mile, unless the self-employed individual can prove that the actual expense is greater;

(c) business taxes, including occupational taxes, gross receipts taxes and property taxes on a place of business other than the home, and business licenses;

(d) rental of equipment, tools and machinery;

(e) rent expense for the place of business, except for the place of business when the individual operates the business out of the individual's residence, unless the individual can demonstrate that the expense has been allowed under federal income tax guidelines;

(f) payments on the principal of the purchase price of income-producing real estate and capital assets, machinery, equipment and other durable goods;

(g) interest paid to purchase income-producing property.

(2) Expenses and costs not allowed:

(a) costs for depreciation, personal business, entertainment expenses and personal transportation to and from work; and

(b) expenses or costs of self-employment that are reimbursed by other agencies cannot also be claimed as costs of self-employment, such as, but not limited to, reimbursements made through USDA to individuals who provide home child care.

(3) Expenses or costs that exceed self-employment income shall not be deducted from other income.

C. Living expense deduction:

(1) Allowing the deduction in the GA-disabled adult program: The living expense deduction is allowed with no time limit as follows:

(a) $125 and one-half of the remainder for a single-adult benefit group;

(b) $225 and one-half of the remainder for a benefit group that includes two adults.

(2) Allowing the deduction in a GA-unrelated child benefit group: The living expense deduction shall be allowed when the caretaker of an unrelated dependent child chooses to be included as a benefit group member. The living expense deduction is allowed with no time limit as follows:

(a) $125 and one-half of the remainder for a single-adult benefit group;

(b) $225 and one-half of the remainder for a benefit group that includes the unrelated caretaker and his or her spouse.

D. Child care costs: Out-of-pocket expenses for child care apply only to the GA-unrelated child benefit group. Expenses paid by the unrelated caretaker for the dependent child included in the benefit group that are necessary due to employment of the caretaker shall be allowed.

(1) From earnings remaining after allowing the work incentive deduction, deduct an amount not to exceed $200 per month for a child under age two and $175 per month for a child age two or older.

(2) If both the caretaker and spouse of the caretaker are working, child care expenses shall be allocated to maximize the available deduction to the benefit group.

(3) The total amount deducted per child shall not exceed the applicable limits set forth above.

[8.106.520.12 NMAC - N, 07/01/2004]

8.106.520.13 UNEARNED INCOME

A. Definition of unearned income: Unearned income means old age, survivors and disability insurance payments (social security), railroad retirement benefits, veterans administration compensation or pension payments, military retirement and allotments, pensions, annuities and retirement benefits; lodge or fraternal benefits, any other public or private disability or retirement benefit or pension, shared shelter payments, individual Indian money (IIM); royalty or lease payments for land or property owned by a benefit group member; settlement payments resulting from insurance or litigation; worker's compensation benefits; child support; unemployment compensation benefits; union benefits paid in cash; gifts and contributions; and real property income.

B. Special considerations:

(1) Direct receipt of child support: Child support payments directly received by an unrelated caretaker and retained by the caretaker are considered available to the benefit group in their entirety, whether or not the caretaker chooses to be included in the benefit group.

(2) Real property income: Income from real property is considered as unearned income when an individual included in the benefit group engages in the management of the property less than 20 hours a week. Costs associated with maintenance of the property or the production of income for which the benefit group is responsible are deducted from the income received for the use of the property.

(3) Alien sponsor income: All of the income of the alien sponsor and sponsor's spouse is counted as unearned income to the benefit group.

[8.106.520.13 NMAC - N, 07/01/2004]

8.106.520.14 NET COUNTABLE INCOME: The earned income remaining after all allowable exemptions and deductions shall be added to the unearned income belonging to the benefit group. The resulting amount shall be the net countable income of benefit group members. The net countable income shall be used to determine the cash assistance payment to the benefit group.

[8.106.520.14 NMAC - N, 07/01/2004]

History of 8.106.520 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 610 DESCRIPTION OF PROGRAM/BENEFITS - BENEFIT DELIVERY

8.106.610.1 ISSUING AGENCY: New Mexico Human Services Department.

[8.106.610.1 NMAC - N, 07/01/2004]

8.106.610.2 SCOPE: The rule applies to the general public.

[8.106.610.2 NMAC - N, 07/01/2004]

8.106.610.3 STATUTORY

AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.
[8.106.610.3 NMAC - N, 07/01/2004]

8.106.610.4 DURATION: Permanent.
[8.106.610.4 NMAC - N, 07/01/2004]

8.106.610.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.106.610.5 NMAC - N, 07/01/2004]

8.106.610.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low income individual at the time of death.
[8.106.610.6 NMAC - N, 07/01/2004]

8.106.610.7 DEFINITIONS: [Reserved]
[8.106.610.7 NMAC - N, 07/01/2004]

8.106.610.8 CASH ASSISTANCE ISSUANCE

A. Method of payment: GA cash assistance benefits are paid by deposit of funds into an electronic benefit transfer (EBT) account.

(1) The initial month's GA cash assistance payment is posted to the benefit group's EBT account on the first working day after the date of authorization.

(2) Cash assistance payments are deposited into the recipient's EBT account so that the funds are available to the benefit group on the first working day of the month.

B. Authorizing payments:

(1) GA benefit payments are authorized, changed or terminated through the department's automated eligibility system.

(2) An initial month's cash assistance payment that is issued by warrant is sent by mail on the first working day after the date of authorization.

C. Initiation of payment:

(1) The initial month's GA cash assistance payment is prorated from the date of application.

(2) A benefit group may be eligible for payment in the application month, but is not eligible for the month following the month of application.

D. Ongoing monthly issuance: Ongoing cash assistance payments are authorized in the regular monthly issuance process.

(1) The payment amount remains the same from month to month in the certification period, unless changes are made that affect eligibility or benefit amount.

(2) Warrants: During the monthly issuance process, if necessary, hard copy checks are written the night before the third to the last working day of the month. They are mailed so as to arrive on or about the first mail delivery day of the month.

E. Change in amount of payment:

(1) After approval, there is a continuing responsibility on the part of both the benefit group and the caseworker to make sure that eligibility and benefit amount are correctly determined. Failure on either side to recognize and carry out this responsibility can result in overpayment to the benefit group. Overpayments for any reason are charged to the benefit group and must be repaid to the department.

(2) A benefit group's cash assistance payment shall be increased or decreased after receipt and verification of information indicating that changes in a benefit group's circumstances affect the amount of assistance to which the benefit group is entitled.

(3) Changes in the payment amount shall be made in accordance with changes in program regulations and/or the standard of need.

F. Affecting changes:

(1) A change in the benefit group's circumstances may change the cash assistance amount for which the group is eligible.

(2) The cash assistance payment reduction or termination of benefits shall be effective in the month following the month the notice of adverse action expires.

(3) The cash assistance payment will be reduced in the month following issuance of a notification of change in circumstances, when the benefit group reports a change in writing, an adult has signed the written report, and the caseworker has sufficient information to effect the change in benefit amount.

(4) If a change in benefit amount occurs as a result of an untimely report by the benefit group, an overpayment or underpayment may occur. If an underpayment occurs, it shall be corrected by issuing a supplemental payment effective the month following the month the change is verified. In case of an overpayment, an overpayment claim shall be established for all appropriate months and efforts shall be made to recover the overpayment from the benefit group.

G. Whereabouts unknown: Benefits shall be terminated if the whereabouts of the benefit group are unknown to the department. A benefit group's whereabouts shall be considered to be unknown if:

(1) mail sent to the last known address is returned to the department indicating that the benefit group no longer lives at that address and at least 30 days have passed since the caseworker sent the mail;

(2) warrants for two consecutive months are returned to the HSD accounting section of the administrative services division; or

(3) the benefit group does not make any withdrawals from the benefit group's EBT account for 60 days or more.
[8.106.610.8 NMAC - N, 07/01/2004]

History of 8.106.610 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
INCOME SUPPORT DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 620 DESCRIPTION OF PROGRAM BENEFITS - BENEFIT DETERMINATION/GENERAL

8.106.620.1 ISSUING AGENCY: New Mexico Human Services Department.
[8.106.620.1 NMAC - N, 07/01/2004]

8.106.620.2 SCOPE: The rule applies to the general public.
[8.106.620.2 NMAC - N, 07/01/2004]

8.106.620.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.
[8.106.620.3 NMAC - N, 07/01/2004]

8.106.620.4 DURATION: Permanent.
[8.106.620.4 NMAC - N, 07/01/2004]

8.106.620.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.106.620.5 NMAC - N, 07/01/2004]

8.106.620.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low-income individual at the time of death.
[8.106.620.6 NMAC - N, 07/01/2004]

8.106.620.7 DEFINITIONS: [Reserved]
[8.106.620.7 NMAC - N, 07/01/2004]

8.106.620.8 PAYMENT DETERMINATION:

A. Determining countable benefit group income: The benefit group's net countable income shall be considered in the payment determination. The benefit group's net countable income is subtracted from the standard of need for the size of the benefit group.

B. Determining the payment:

(1) A benefit group whose net countable income equals or exceeds the standard of need for the size of the benefit group shall not be eligible for GA benefits.

(2) For a benefit group whose net countable income does not exceed the standard of need for the size of the benefit group, the benefit amount shall be determined by:

(a) subtracting the benefit group's countable income from the standard of need for the size of the benefit group;

(b) subtracting any sanction amount, if applicable; and

(c) subtracting any recoupment amount, if applicable.
[8.106.620.8 NMAC - N, 07/01/2004]

8.106.620.9 RECOUPMENT: An individual against whom there is an outstanding claim for overpayment of cash assistance shall be required to repay the claims. Recovery of an overpayment may be accomplished by recoupment (see 8.106.640.11 NMAC). Recoupment amounts shall be deducted from the monthly benefit after the sanction amount is deducted, if appropriate.
[8.106.620.9 NMAC - N, 07/01/2004]

8.106.620.10 CHILD SUPPORT PAYMENT SANCTIONS - GA UNRELATED CHILD PROGRAM

A. General:

(1) Failure by an adult caretaker of an unrelated dependent child to comply with child support cooperation requirements shall result in a payment reduction of 25% for the first occurrence, 50% for the second occurrence and case closure for the third occurrence. Cases closed due to sanctioning are ineligible for a period of six months.

(2) Before imposing the first sanction, the caretaker shall be given the opportunity to meet child support requirements through a conciliation process. If the individual does not agree to cooperate by the end of the conciliation period, a payment sanction shall be imposed. The reduction shall be applied to the benefit group's standard of need.

(3) Child support cooperation requirements shall be applicable to the caretaker adult even if the adult is not included in the benefit group. Payment sanctions shall be applicable to benefit group's standard of need even if the caretaker adult is not included in the benefit group.

B. The conciliation process:

(1) When conciliation is available: Conciliation shall be available to an individual once during an occurrence of assistance. Once a conciliation period has been made available to the benefit group, there must be a period of at least 12 months between occurrences of assistance in order for a conciliation to be available again to the benefit group.

(2) Occurrence of assistance: An occurrence of assistance means a continuous period in which a benefit group receives GA benefits.

(3) Determining that noncompliance has occurred: The determination of noncompliance with child support shall be made by CSED. The conciliation and sanctioning process for child support noncompliance is initiated by the department upon receipt of notice from CSED that the caretaker has failed to cooperate.

(4) Initiating conciliation: Within ten days of notification by CSED that the caretaker has not complied, the caseworker shall take action to initiate a conciliation period, if the individual's conciliation has not been used. A conciliation is initiated by the caseworker issuing a conciliation notice.

(5) Conciliation period:

(a) Conciliation is a 30-day period during which the caretaker has the opportunity to correct whatever failure resulted in the noncompliance determination. The conciliation process shall occur only once prior to the imposition of the sanction. The benefit group shall be subject to sanction in the month following the month the notice of adverse action expires.

(b) If CSED determines that the adult caretaker is not complying with child support requirements, the adult caretaker shall be required to enter into a conciliation process established by HSD to address the noncompliance, or to identify good cause for noncompliance or barriers to compliance, if applicable.

(c) The adult caretaker shall have ten working days from the date a conciliation notice is mailed to contact HSD to initiate the conciliation process. An adult caretaker who fails to initiate the conciliation process shall have a notice of adverse action mailed after the tenth working day following the date on which the conciliation notice is mailed. An adult caretaker who begins, but does not complete, the conciliation process shall be mailed a notice of adverse action 30 days from the date the original conciliation was initiated.

(d) If the adult caretaker has initiated the conciliation process, it is the adult caretaker's responsibility to contact CSED and to comply with CSED requirements or to request a waiver. If the caseworker does not receive confirmation from CSED within 30 days of issuing the conciliation notice that the caretaker is cooperating, has a good cause waiver, or has requested a good cause waiver, the conciliation process shall be considered to have failed and the benefit group shall be subject to a payment sanction.

C. Occurrence of noncooperation:

(1) Each instance in which a caretaker is determined by the department to have failed to meet a child support requirement shall be considered a separate occurrence of noncompliance.

(2) When the noncompliance continues for three months without the sanctioned individual reestablishing compliance, progression to the next higher sanction level shall result in the fourth month.

(3) Reestablishing compliance shall allow full payment to resume, or shall appropriately reduce the sanction level for the benefit group in the month following the month in which compliance is established.

D. Cumulative sanctions: Noncompliance sanctions are cumulative as they relate to an individual in the benefit group.

(1) A cumulative sanction shall result when there is more than one failure

by an individual in the benefit group to comply with child support enforcement requirements.

(2) A cumulative sanction, whether or not cured, shall remain the property of the individual benefit group member who caused the sanction. An individual with a cumulative sanction who leaves a benefit group relieves the benefit group of that individual's sanction status.

(3) An individual's compliance shall reverse the sanction level to the benefit group.

(4) An individual's sanction status may be reversed as a result of a hearing decision that renders the sanction invalid.

(5) A third sanction level, which results in a mandatory six-month closure for the benefit group, cannot be reversed.

E. Progressive sanctions: Sanction levels shall be progressive to the benefit group in which the sanctioned individual resides.

(1) When the noncompliance continues for three months without the sanctioned individual reestablishing compliance, progression to the next higher sanction level shall result in the fourth month.

(2) A sanction shall progress until compliance is established by the individual, or there is a waiver of the requirement. Reestablishing compliance shall allow full payment to resume or shall appropriately reduce the sanction level for the benefit group in the month following the month in which compliance is established.

(3) A progressive sanction may be reversed as a result of a hearing decision that renders the sanction level invalid.

(4) An individual's compliance cannot reverse the sanction level attributed to the benefit group. Once a sanction has been imposed, any subsequent sanction is imposed at the next higher level, unless reversed by a hearing decision.

F. Sanctioning:

(1) Within ten days of determining that the caretaker has failed to meet a child support cooperation requirement, ISD shall issue a notice of adverse action informing the benefit group that its cash assistance payment will be reduced. The payment reduction shall take place with the first payment following expiration of the notice of adverse action.

(2) Notice of adverse action shall apply to all child support noncompliance sanctions and levels, including those relating to the conciliation process.

(3) Failure to comply during the 13-day notice of adverse action time period shall cause the sanction to become effective.

(4) Lifting the sanction: An caretaker who corrects the failure of compliance with child support enforcement requirements during the 13-day notice of adverse action time period shall not have the sanction imposed against the benefit group or payment amount.

(a) The sanction shall not count as a cumulative or progressive sanction, since the reason for the sanction was corrected during the notice of adverse action time period and prior to a benefit reduction being imposed.

(b) A sanction shall be removed effective the month following the month in which the determination is made that the individual has complied with requirements.

(c) A child support enforcement sanction shall be removed after CSED notifies the caseworker that the individual is in compliance with child support enforcement requirements.

G. Sanction levels:

(1) First-level sanction:

(a) The first failure to comply, or first level sanction for failure to comply, shall result in a reduction of 25% of the standard of need.

(b) If the first level, or 25% sanction, lasts for three months, or an individual has a second incident of failure to comply, the sanction shall advance to level two, or 50% sanction.

(2) Second-level sanction:

(a) The second level sanction for failure to comply shall result in a reduction of 50% of the standard of need. The second level is initiated by failure to comply for more than three months or a second instance of noncompliance with a CSED requirement.

(b) A failure to meet child support enforcement requirements for three months at the second level, or a third incidence of failure to comply with a requirement shall result in the third sanction level.

(3) Third-level sanction:

(a) The third sanction level results in case closure for a period of not less than six months.

(b) Once an individual is sanctioned at the third level, any subsequent incident of failure to comply shall immediately result in the third level sanction, or case ineligibility for six months.

H. Sanctions by other states or other programs: Individuals in sanction status for failure to comply with the requirements of other programs or other states, such as the food stamp employment and training program shall not carry that sanction status into the GA cash assistance program.

[8.106.620.10 NMAC - N, 07/01/2004]

8.106.620.11 NON-REPORTING SANCTIONS

A. General: The eligibility determination and payment calculation process relies upon applicants and recipients to provide accurate and timely reports of information affecting their eligibility and benefit amount. Payment sanctions for non-reporting shall be established to encourage timely and accurate reporting and to offset benefits resulting from the reporting of inaccurate or misleading information, the untimely reporting of changes, or the failure to report any required information.

B. Length of a sanction: Each non-reporting sanction shall run for a period of four months for the first month in which failure to report occurred. An additional month shall be added for each additional month included in an occurrence of non-reporting until the payment is corrected.

C. Definition of an occurrence of non-reporting: An occurrence of non-reporting exists when an applicant or recipient intentionally fails to report information or reports incorrect information which results in an overpayment of cash assistance benefits.

D. Amount of sanction:

(1) Reporting sanctions shall be calculated at 25% of standard of need for the size of the benefit group being sanctioned.

(2) Reporting sanctions are not progressive. If there is another occurrence of non-reporting prior to the end of an ongoing non-reporting sanction period, the next sanction and any subsequent non-reporting sanctions shall be consecutive and at the 25% level.

(3) Reporting sanctions and child support sanctions shall be integrated into a single calculation to determine the final sanction amount.

(4) If a case closes during a reporting sanction period for reasons other than sanctions, the non-reporting sanction shall be suspended and resumed at the same duration the next time the case is reopened.

E. Procedures: The following steps shall be taken in implementing a payment sanction.

(1) The caseworker shall document and establish an overpayment claim using ISD2 overpayment claims procedures. The caseworker shall also determine whether the recipient was at fault.

(2) The county director or a designated unit supervisor shall review the overpayment and determine the accuracy of the overpayment determination and appropriateness of the fault determination. Upon determining that all is in order, the county director, or designated supervisor shall cause a notice of intent to sanction to be issued to the recipient. Failure of the recipient to contact the person issuing the notice within the 10 working days allowed shall constitute waiver of conciliation rights.

(3) If the recipient requests con-

ciliation within the 10 working days after issuance of the notice, the county director or designated supervisor shall schedule a conciliation conference.

(4) The conciliation conference is conducted by the county director or designated supervisor.

(a) The caseworker shall describe the reporting error, how the amount of the overpayment is determined and the reasons for finding the recipient at fault.

(b) The recipient shall have the opportunity to discuss the overpayment determination, the finding of fault and to show good cause why the sanction should not be imposed.

(c) Based upon this conference, the county director or designated supervisor shall determine whether a sanction should be imposed.

(d) The recipient may represent himself or be represented by someone else. If the recipient wishes to be represented by another individual, the recipient must designate that individual on a form ISD-121.

(5) Following the conference, the county director shall issue written notice stating whether or not the sanction is to be imposed, and, if appropriate, the worker shall effect the sanction causing issuance of a notice of adverse action. The payment reduction takes effect in the month following expiration of the notice of adverse action.

(6) Recipients who disagree with the sanction determination shall have fair hearing rights and access to the fair hearing process.

[8.106.620.11 NMAC - N, 07/01/2004]

History of 8.106.620 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 630 DESCRIPTION OF PROGRAM/BENEFITS - CHANGES IN ELIGIBILITY

8.106.630.1 ISSUING AGENCY: New Mexico Human Services Department.
[8.106.630.1 NMAC - N, 07/01/2004]

8.106.630.2 SCOPE: The rule applies to the general public.
[8.106.630.2 NMAC - N, 07/01/2004]

8.106.630.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.
[8.106.630.3 NMAC - N, 07/01/2004]

8.106.630.4 DURATION: Permanent.
[8.106.630.4 NMAC - N, 07/01/2004]

8.106.630.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.106.630.5 NMAC - N, 07/01/2004]

8.106.630.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low-income individual at the time of death.

[8.106.630.6 NMAC - N, 07/01/2004]

8.106.630.7 DEFINITIONS: [Reserved]
[8.106.630.7 NMAC - N, 07/01/2004]

8.106.630.8 CHANGE PROCESSING STANDARDS:

A. There is a continuing responsibility on the part of both the recipient and the caseworker to make sure that benefits paid to the benefit group correctly reflect the benefit group's circumstances for the certification period.

B. A change is considered reported on the date the report of change is received by the local county office or, if mailed, the date of the postmark on the benefit group's report, plus three days mailing time.

C. A benefit group will be encouraged to use a change report form to document changes. A change may be reported by mail, by personal visit, by telephone, fax, electronic mail.

D. Department action on reported changes: Reported changes shall be evaluated and eligibility and/or benefit amount changes shall be acted on within 10 days of receiving the notice of a change.

(1) The change is made as soon as possible but must be effected no later than the end of the month following the month in which the change is reported.

(2) The caseworker shall take action on any change reported by a benefit group, and on any change that becomes known to the department through other sources.

[8.106.630.8 NMAC - N, 07/01/2004]

8.106.630.9 CHANGE PROCESSING ACTION: If, during a certification period, a change occurs that affects eligibility or benefit amount, the caseworker shall take action to adjust the benefit group's eligibility or benefit amount.

A. Action on changes: When a benefit group reports a change, the caseworker must take action to determine the benefit group's eligibility and benefit amount within ten days of the date the notice of change is received by the ISD county office.

B. Reducing the benefit amount: For changes that result in a reduction of cash assistance benefits, the caseworker shall act on the change as follows.

(1) If a signed written report is provided by the benefit group, action shall be taken for the following month without issuing a notice of adverse action. The benefit group shall be provided with adequate notice. If the benefits will be reduced in the same month in which the certification period will expire, no action shall be required to reduce or terminate benefits.

(2) When a benefit group timely reports a change that will reduce benefits, but does not provide a signed written report, the caseworker shall issue an adverse action notice to the benefit group. If the adverse action time limit expires in the following month, there is no overpayment in that month and the benefit group is entitled to the higher benefit amount. The reduction shall be effective in the month following the month in which the adverse action notice expires.

(3) If the change is reported by any other means, within 10 days the caseworker shall take action to issue a notice of adverse action to reduce or terminate benefits effective the month following the month in which the adverse action time limit expires. If the notice of adverse action time limit will expire in the same month that the benefit group's certification period will expire, no action shall be required to reduce or terminate benefits.

C. Increased benefit amount:

(1) If verification of the change is provided at the time the change is reported, the caseworker shall make the change prospective, beginning in the month following the month in which the change was

reported.

(2) If verification is not provided at the time the change is reported, the benefit group shall be allowed 13 days from the date a change is reported to provide verification. Benefits shall be increased effective the month following the month in which the verification is provided.

(3) When a benefit group fails to make a timely report of a change that will result in an increased benefit amount, the benefit amount shall increase the month following the month in which the verification is provided. The benefit group is not entitled to an increased benefit amount for any month prior to the month in which the verification is provided.

D. Termination of benefits: When the benefit group reports a change that will result in a termination of benefits, and the change is not reported in writing and signed by a benefit group member, the caseworker shall issue an adverse action notice.

(1) If the adverse action time limit expires in the month following the month the notice is mailed, there is no overpayment to the benefit group in the following month and the benefit group shall be entitled to the higher benefit amount. A claim against the benefit group shall not be established.

(2) If the adverse action time limit will expire in the same month in which the certification period ends, or after the certification period ends, no action shall be taken to terminate benefits and the certification period shall be allowed to expire. The caseworker shall document the change in the case record.

E. No change in benefit amount: When a reported change will not change the benefit amount, the caseworker shall document the change in the case file and notify the benefit group that the report was received and there is no change in benefits.

F. Other changes: All unreported changes of which the caseworker becomes aware must be acted upon. At a minimum, this means documenting changes in the case record. All discrepancies and questionable information shall be resolved to make sure that the correct benefit amount is issued to the benefit group.

[8.106.630.9 NMAC - N, 07/01/2004]

8.106.630.10 CHANGE NOTICES:

A. Notice of adverse action: Prior to any action to reduce or terminate cash assistance benefits within the certification period, the benefit group shall be provided with a notice of an adverse action, unless the change was reported by the benefit group in writing and was signed by a benefit group member. The adverse action notice shall include at least the following information:

(1) proposed action and reason for the action;

(2) month in which the change takes effect;

(3) adjusted benefit amount;

(4) benefit group's right to request a fair hearing, circumstances under which the benefit group can continue benefits at the greater amount, and deadline dates for requesting a hearing;

(5) benefit group's liability for any benefits overpaid if the result of the fair hearing is that the department took the correct action;

(6) general information on whom to contact for additional information, including the right to representation by legal services.

B. Adequate notice: If a change was reported by the benefit group in writing, was signed by a benefit group member, and will result in a reduction or termination in benefits, the benefit group shall be provided with advance written notice of the reduction or termination.

(1) The benefit group shall be notified that its benefits are being reduced or terminated no later than the date the benefit group receives, or would have received, its benefits.

(2) Adequate notice shall be provided when changes reported in writing meet the following conditions:

(a) the benefit group provides a written report of the information that results in the reduction or termination and the report is signed by a member of the benefit group;

(b) the caseworker can determine the benefit group's reduced benefit amount or ineligibility based solely on the information provided by the benefit group in the written report; and

(c) the benefit group retains its right to a fair hearing.

C. Fair hearing rights: The benefit group retains its right to have continued benefits if the fair hearing is requested within the adverse action time limit and the benefit group requests the higher benefit amount pending the hearing decision. The caseworker shall continue the benefit group's previous benefit amount if required, within five working days of the benefit group's request.

D. Other changes: A notice of adverse action shall not be provided when:

(1) there is a mass change in benefits affecting the entire GA program;

(2) the caseworker determines, on the basis of reliable information, that the benefit group has moved from the project area;

(3) the caseworker determines on the basis of reliable information that all members of a benefit group have died;

(4) the benefit group has received an increased benefit amount to restore lost benefits, the restoration is complete, and the benefit group has been notified in writing of the date the increased benefit amount will terminate;

(5) the benefit group voluntarily requests in writing, or in the presence of the caseworker, that its participation be terminated; or

(6) the caseworker determines, on the basis of reliable information, that the benefit group has been approved for a concurrent cash assistance program.

[8.106.630.10 NMAC - N, 07/01/2004]

8.106.630.11 LATE REPORTING OF CHANGES

A. If the benefit group failed to timely report a change, the caseworker shall verify the change to determine whether the benefit group received benefits to which it was not entitled (an overpayment).

B. Failure to report changes: Failure to report any change in a timely manner may result in an underpayment or an overpayment to the benefit group.

(1) The caseworker shall establish a claim against the benefit group for any month in which the benefit group was overpaid benefits.

(2) If the establishment of an overpayment is made within the certification period, the benefit group is entitled to a notice of adverse action that its benefits will be reduced due to the overpayment.

(3) No claim shall be established because of a change in circumstances that a benefit group is not required to report.

C. Good cause for failure to report a required change:

(1) If a required change is not reported timely, good cause for not reporting on time is considered to exist if the recipient can show, with appropriate documentation, that the recipient was prevented from reporting by a health problem, including illness, or death of an immediate family member during the time period the individual was required to report.

(2) The health problem or death of an immediate family member must have been of such severity and duration as to effectively prevent the timely reporting by the head of household or unrelated caretaker. The head of household or unrelated caretaker must provide proof of the existence of the health problem and explain exactly how it prevented the recipient from reporting the information to the ISD office.

(3) The determination of good

cause shall be made by the caseworker, subject to the review and approval of the county director or the county director's designee.
[8.106.630.11 NMAC - N, 07/01/2004]

History of 8.106.630 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 640 DESCRIPTION OF PROGRAM/BENEFITS - BENEFIT CORRECTIONS

8.106.640.1 ISSUING AGENCY: New Mexico Human Services Department.
[8.106.640.1 NMAC - N, 07/01/2004]

8.106.640.2 SCOPE: The rule applies to the general public.
[8.106.640.2 NMAC - N, 07/01/2004]

8.106.640.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.
[8.106.640.3 NMAC - N, 07/01/2004]

8.106.640.4 DURATION: Permanent.
[8.106.640.4 NMAC - N, 07/01/2004]

8.106.640.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.106.640.5 NMAC - N, 07/01/2004]

8.106.640.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low-income individual at the time of death.
[8.106.640.6 NMAC - N, 07/01/2004]

8.106.640.7 DEFINITIONS: [RESERVED]
[8.106.640.7 NMAC - N, 07/01/2004]

8.106.640.8 ERRONEOUS PAYMENT PROVISIONS:

A. An erroneous payment occurs when an error is made by the client or the department that resulted in an underpayment or over-payment of cash assistance benefits.

B. For each month of eligibility, the determination of the benefit amount is made using the standard of need, case information, and regulations in effect for that month. The payment error is the difference between the benefit which was issued and the benefit which would have been issued if the error had not been made.

C. First month of an erroneous payment: The first month in which a benefit is considered erroneous is the month in which the benefit group received a cash assistance payment differing from the amount that the benefit group was entitled to receive. In the case of an overpayment, the first month of the over payment shall be the month following the month in which the adverse action notice time limit would have expired if the benefit group had timely reported the change.

D. Last month of an erroneous payment: The period of erroneous payment ends on the last day of the last month in which payment is corrected. In the case of an overpayment, if the period of overpayment has been extended while a proposed reduction or termination is the subject of an administrative hearing, and the hearing decision is in the department's favor, the amount overpaid pending the administrative hearing decision is included as part of the reported claim.
[8.106.640.8 NMAC - N, 07/01/2004]

8.106.640.9 UNDERPAYMENT OF BENEFITS

A. An underpayment occurs if the department issues a lower benefit amount than the benefit group was entitled to receive. An underpayment of cash assistance shall be corrected if the underpaid benefit group:

(1) is currently eligible under the program of assistance in which the error occurred; or

(2) would be eligible except for the error causing the underpayment.

B. An underpayment to a denied applicant, or to a former recipient who is not eligible at the time the error is discovered, shall be corrected if the individual becomes eligible at a later date.

C. Before issuing a benefit correcting an underpayment, the department shall subtract from the amount owed to the recipient any outstanding claim against the recipient in the program for which the underpayment is being corrected.

D. If a change occurred that made the benefit group eligible for a higher payment for a month and the change was verified, but the department failed to act on the change, the department shall make the difference available to the benefit group. The benefit group must have timely reported the change.

E. Underpayments shall be corrected:

(1) by issuing a supplemental benefit for the month benefits were underpaid, if timely reported;

(2) by issuing a supplemental benefit to current cases upon their discovery; or

(3) by recording the underpayment amount due to individuals who are not currently eligible and issuing a supplemental payment should the individual reapply in the future.

F. Correcting benefits: Underpayments are corrected by making changes to historical months in the department's automated benefit delivery system. An administrative error that resulted in a higher payment than was actually issued for the historical month shall result in issuance of a supplemental payment correcting the error.

G. A failure of the benefit group to timely report a change that would have resulted in a supplemental payment for any historical month shall not result in issuance of a supplemental payment to the benefit group.
[8.106.640.9 NMAC - N, 07/01/2004]

8.106.640.10 OVERPAYMENT OF BENEFITS

A. An overpayment occurs:

(1) if the department issues more than the benefit group was eligible to receive because of an administrative error; or

(2) if the benefit group fails, either intentionally or unintentionally, to report correct information at application or while receiving benefits.

B. The department shall recover all cash assistance overpayments, including overpayments resulting from an administrative error, and any assistance paid while an administrative hearing decision is pending.

C. An historical change, which results in a lower payment than was originally issued, results in an overpayment and in the establishment of a claim for the month that benefits were overpaid to the

benefit group.

D. The overpayment is reported to the department's restitution services bureau for entry into the claims system and establishment of claim against the benefit group in the amount of the overpayment.

E. Benefit group responsibility for repayment: The department shall pursue recovery of an overpayment from:

(1) the benefit group which was overpaid;

(2) a benefit group in which an adult member of the overpaid benefit group later becomes a member; or

(3) any adult member of the overpaid benefit group, whether or not the adult is currently receiving assistance.

F. Overpayments to sponsored aliens:

(1) Aliens and sponsors are jointly liable for overpayments caused by failure of the sponsor to provide correct information, unless the sponsor is without fault or has good cause.

(2) "Without fault" or "good cause" exists when:

(a) the agency failed to request information from the sponsor; or

(b) the sponsor can show that he or she provided all information available at the time the information was provided;

(c) the alien provided incorrect information without the knowledge of the sponsor; or

(d) the sponsor can show that the giving of incorrect information was not intentional on the part of the sponsor.

(3) If good cause is found to exist, the alien has sole responsibility for repayment.

G. Overpayments shall be recovered through recoupment or repayment. All overpayments are subject to recovery. Overpayments shall be promptly reported and the appropriate recovery mechanism initiated.

H. Developing substantiating information:

(1) The department shall determine whether an overpayment has occurred. Pertinent information shall be requested from the recipient.

(2) Because information relevant to an overpayment can be used to prosecute the recipient for fraud, the recipient shall not be required to provide such information; however, if the recipient declines to provide information crucial to the determination of an overpayment, the benefit group will be considered to have been totally ineligible for the cash assistance benefits in the historical month.

(3) Actual income received in the historical month is used to determine the amount of the overpayment. The benefit group is entitled to all allowable deductions from income to determine the corrected benefit amount.

(4) The recipient shall become ineligible on a continuing basis if there is a continuing failure to provide information affecting the recipient's current eligibility.

I. Establishing a claim: Overpayments shall be determined and a claim established by making changes to one or more historical months in which the benefit group received more benefits than it was entitled to receive. The department may make changes in the department's automated benefit delivery system or may calculate the overpayment and report the overpayment amount on a paper form.

J. Hearings: The benefit group shall be entitled to a fair hearing regarding an overpayment in accordance with fair hearings provisions set forth at 8.100.970 NMAC. A fair hearing must be requested within 90 days from the date on the overpayment notice.

[8.106.640.10 NMAC - N, 07/01/2004]

8.106.640.11 RECOVERY OF OVER PAID BENEFITS:

A. Restitution services bureau: The office of inspector general, through the restitution services bureau, is responsible for managing the department's claims system, including recovery through recoupment of benefits and/or repayment of overpaid benefits by any other means.

B. Repayment: A repayment is a cash payment made to the department by the overpaid recipient. Repayments are used to recover cash assistance overpayments from cases no longer receiving cash assistance, or where recovery of an overpayment from an open cash assistance case cannot be made within 20 months by recoupment alone.

C. The amount the department will recover monthly through repayment is based on a repayment schedule, or, if a court order for repayment exists, in accordance with the court order.

D. If the level of payment sought would result in an extreme hardship on the individual, the restitution services bureau may agree to accept a lesser amount. The restitution services bureau is responsible for making arrangements for repayments.

E. Repayment Schedule:

(1) Overpayment amount from $35 - $100, monthly repayment amount shall be $5.00.

(2) Overpayment amount from $101 - $200, monthly repayment amount shall be $10.00.

(3) Overpayment amount from $201 - $300, monthly repayment amount shall be $15.00.

(4) Overpayment amount from $301 - $400, monthly repayment amount shall be $20.00.

(5) Overpayment amount from $401 - $500, monthly repayment amount shall be $25.00.

(6) Overpayment amount from $501 - $600, monthly repayment amount shall be $30.00.

(7) Overpayment amount from $601 - $700, monthly repayment amount shall be $35.00.

(8) Overpayment amount from $701 - $800, monthly repayment amount shall be $40.00.

(9) Overpayment amount from $801 - $900, monthly repayment amount shall be $45.00.

(10) Overpayment amount from $901 - or more, monthly repayment amount shall be $50.00.

F. Recoupment: Recoupment shall be used to recover cash assistance overpayments from an active cash assistance case. The recoupment amount is automatically recovered before the payment is issued to the benefit group. The amount recouped is equal to 15% of the benefit group's standard of need. Recoupment is the last step in the calculation prior to determining the payment amount for the benefit group.

G. Notice:

(1) Written notice of an overpayment shall be sent to the recipient before any attempt to recover the overpayment is made.

(2) No action to reduce the payment shall be taken during the notice of adverse action time period.

(3) The notice of overpayment informs the recipient:

(a) that an overpayment report has been filed;

(b) what action the department intends to take with regard to the overpayment;

(c) that the recipient may request a fair hearing on the issue of the overpayment; and

(d) that the recipient need not give testimony at the hearing.

H. Fraud exception: Notice of overpayment and administrative hearings rights shall not be given if the department has decided to refer the matter to the district attorney's office to pursue criminal prosecution for fraud. In such cases, the recipient's notice rights are limited to those afforded by state criminal statutes. No attempt shall be made by ISD staff to recover overpayments in such cases, nor shall any offers to refund the overpayment be accepted by the ISD county office.

I. Recovery action:

(1) Overpayments of less than $1,000: Overpayments of less than $1,000 to currently eligible cases shall be immediately processed by the caseworker for recoupment.

(2) Overpayments over $1,000: Overpayments of $1,000 or more to currently eligible cases shall be referred to the restitution services bureau for investigation and a fraud action decision.

(3) Overpayments to closed cases: Overpayments of $35 or more to closed cases shall be referred to the restitution services bureau for collection.

(4) Response to referral:

(a) The caseworker shall be notified by the office of inspector general (OIG) within 90 days whether fraud action has or will be taken on an open case. If no fraud action is contemplated, the case shall be immediately processed for either recoupment or cash recovery.

(b) If a response is not received from the OIG within 90 days of referral, the ISD county office may initiate recoupment from currently eligible cases.

J. Fraud referral:

(1) Fraud elements:

(a) By state statute, Section 30-16-6, NMSA 1978, fraud is the intentional misappropriation or taking of anything of value which belongs to another by means of fraudulent conduct, practices or representations.

(b) Fraud exists when:

(i) a person, by words or conduct, misrepresents facts to the department with the intention of deceiving the department; and

(ii) as a result of the misrepresentation and the department's reliance upon it, the individual has obtained cash benefits from the department to which he or she was not entitled.

(2) Referral for investigation: If a caseworker determines that fraud may exist, the case shall be referred to the office of inspector general for further investigation or possible referral for prosecution.

[8.106.640.11 NMAC - N, 07/01/2004]

History of 8.106.640 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

This is an amendment to 8.102.410 NMAC, Section 10 and Section 12. The amendment at Section 10 re-issues regulations related to the eligibility of non-citizens to receive TANF funded cash assistance. The amendment at Section 12 repeals any reference to the state-funded General Assistance program and adult residential care program.

8.102.410.10 CITIZENSHIP AND ALIEN STATUS:

[~~**A.** To be eligible for inclusion in a NMW benefit group and to receive federal TANF funding, an individual must be:~~

~~**(1)** A citizen of the United States; or~~

~~**(2)** An alien who entered the United States prior to August 22, 1996, as one of the classes of aliens described in Subsection B of 8.102.410.10 NMAC; or~~

~~**(3)** An alien who entered the United States as a qualified alien on or after August 22, 1996, and who has met the five-year bar or one of the exceptions to the five-year bar listed in Subsection C of 8.102.410.10 NMAC.~~

~~**B.** Aliens Who Entered the United States Prior to August 22,1996: An alien who entered the United States prior to August 22, 1996, is not subject to the five-year bar on eligibility for purposes of cash assistance eligibility and will continue to be eligible for cash assistance on the basis of alien regulations in effect prior to August 22, 1996. These classes of aliens are:~~

~~**(1)** Aliens lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law, including certain aliens lawfully present in the United States as result of the application of the following provisions of the Immigration and Nationality Act:~~

~~**(a)** Section 207(e), in effect after March 31, 1980 -- aliens admitted as refugees;~~

~~**(b)** Section 203(a)(7) in effect prior to April 1, 1980 -- individuals who were granted status as conditional entrant refugees;~~

~~**(c)** Section 208 -- aliens granted political asylum by the Attorney General;~~

~~**(d)** Section 212(d)(5) -- aliens granted temporary parole status by the Attorney General, or aliens granted lawful temporary status pursuant to Section 201, 302, or 303 of the Immigration Reform and Control Act of 1986 who must be either:~~

~~**(i)** a Cuban and Haitian entrant as defined in paragraph (1) or (2)(A) or Section 501(e) of the Public Law 96-422, or~~

~~**(ii)** an applicant for NMW who is not a Cuban and Haitian entrant who was adjusted to lawful resident status more than five years prior to application.~~

~~**(2)** All other aliens granted lawful temporary or permanent resident status, pursuant to Section 201, 302, or 303 of the Immigration Reform and Control Act of 1986, are disqualified for five years from the date lawful temporary resident status is granted.~~

~~**C.** Aliens Who Entered the United States On or After August 22, 1996:~~

~~**(1)** An alien who entered the United States on or after August 22, 1996 with the status of "qualified alien", shall be barred from cash assistance funded by the federal TANF block grant for a period of five years, beginning on the date of the alien's entry into the United States, with the following exceptions:~~

~~**(a)** an alien admitted to the United States as a refugee under section 207 of the Immigration and Nationality1 Act;~~

~~**(b)** an alien granted asylum under section 208 of the Immigration and Nationality Act;~~

~~**(c)** an alien whose deportation is withheld under section 243(h) of the Immigration and Nationality Act; or~~

~~**(d)** an alien who is lawfully residing in the state and who is a veteran with an honorable discharge not on account of alien status; who is on active duty, other than on active duty for training, in the armed forces of the United States; or who is the spouse or unmarried dependent child under the age of 18 of such veteran or active duty alien.~~

~~**(e)** an alien granted status as a Cuban or Haitian entrant, as defined in Section 501(e)of the Refugee Education Assistance Act of 1980.~~

~~**(2)** A "qualified alien", for purposes of this regulation, is an alien who, at the time the alien applies for, receives, or attempts to receive a federal public benefit, is:~~

~~**(a)** an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act, or~~

~~**(b)** an alien who is granted asylum under Section 208 of such Act, or~~

~~**(c)** a refugee who is admitted to the United States under Section 207 of the Act (including certain Amerasian immigrants as refugees), or~~

~~**(d)** an alien who is paroled into the United States under Section 212(d)(5) of such Act for a period of at least 1 year, or~~

~~**(e)** an alien whose deportation is being withheld under Section 243(h) of such Act, or~~

~~**(f)** an alien who is granted conditional entry pursuant to 203(a)(7) of such Act as in effect prior to April 1, 1980.~~

~~**(g)** an alien who is a Cuban or Haitian entrant (as defined in Subsection 501(e) of the Refugee Education Assistance Act of 1980; or~~

~~**(h)** Certain battered women and alien children of battered parents (Only those who have begun the process of becoming lawful permanent residents under the Violence Against Women Act).~~

~~**D. State-Funded Alien**~~

~~Eligibles:~~

~~(1) An alien who entered the United States on or after August 22, 1996, as one of the classes of aliens described in Subsection B of 8.102.410.10 NMAC, is eligible with respect to citizenship requirements, for state-funded assistance under NMW and GA without regard to how long the alien may have been residing in the United States. Federally ineligible aliens living in NMW households are included in the NMW benefit group. Such individuals are not eligible for Medicaid. An alien who would qualify for federal TANF with respect to citizenship requirements shall not be eligible for wholly state-funded assistance under this provision.~~

~~(2) Aliens who are disabled adults or children not living with adults and who are not eligible for NMW are included in a GA benefit group, provided the individual meets all other GA requirements. Payment to this group of individuals is subject to the availability of state GA funding. Individuals included in an NMW group are subject to removal from the group if the GA program is suspended or terminated.~~

~~(3) Individuals included in an NMW grant pursuant to this provision are subject to all NMW eligibility requirements, including work program requirements.~~]

A. Eligibility for TANF funded cash assistance:

(1) Participation in the NMW cash assistance program is limited to a U.S. citizen, a naturalized citizen or a non-citizen U.S. national.

(2) A non-citizen, other than a non-citizen U.S. national, must be both a qualified and eligible alien in order to participate in the NMW cash assistance program.

B. Definitions:

(1) Continuously lived in the U.S.: means that a non-citizen has lived in the U.S. without a single absence of more than 30 days or has lived in the U.S. without a total of aggregated absences of more than 90 days.

(2) Federal means-tested public benefit: means benefits from the food stamp program; the food assistance block grant programs in Puerto Rico, American Samoa, and the commonwealth of the Northern Mariana Islands; supplemental security income (SSI); and the TANF block grant program under title IV of the Social Security Act; medicaid, and SCHIP.

(3) Five-year bar: means the federally imposed prohibition on receiving federal means-tested public benefits for certain qualified aliens who entered the United States on or after August 22, 1996, until they have continuously lived in the U.S for five years. If an alien enters the U.S. on or after August 22, 1996, but does not meet the definition of a qualified alien, the five-year bar begins on the date the non-citizen attains qualified alien status.

(4) Immigrant: means a non-citizen or an alien within the meaning found in title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

(5) Non-citizen U.S. national: means a person who is not a U.S. citizen but was born in an outlying possession of the United States on or after the date the U.S. acquired the possession, or a person whose parents are non-citizen U.S. nationals. A person who resides on one of the following U.S. island territories is a non-citizen U.S. national: American Samoa, Swains island or the Northern Mariana islands.

(6) Permanently residing under color of law (PRUCOL): means a person whose presence in the US is known by the department of homeland security (DHS) and the DHS does not intend to deport the person. Persons classified as PRUCOL may or may not also be qualified aliens.

(7) Qualified alien: means a non-citizen:

(a) who is lawfully admitted for permanent residence under the Immigration and Nationality Act (an LPR);

(b) who is granted asylum under section 208 of the INA (an asylee);

(c) who is a refugee admitted to the U.S. under section 207 of the INA (a refugee);

(d) who is paroled into the U.S. under section 212(d)(5) of the INA for at least one year (a parolee);

(e) whose deportation is being withheld under section 241(b)(3) or 243(h) of the INA;

(f) who is granted conditional entry pursuant to section 203(a)(7) of the INA as in effect prior to April 1, 1980;

(g) who is a Cuban or Haitian entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980;

(h) who is a victim of a severe form of trafficking, regardless of immigration status, under the Trafficking Victims Protection Act of 2000.

(8) Qualified alien due to battery or extreme cruelty: means a non-citizen, regardless of alien status, who has been battered or subjected to extreme cruelty, as long as the following elements are met:

(a) there is a substantial connection between such battery or cruelty and the need for the cash benefits; and

(b) the abused non-citizen is not currently living with the abuser; and

(c) the INS or executive office of immigration review (EOIR) has:

(i) approved a self-petition seeking permanent residency, or

(ii) approved a petition for a family based immigrant visa; or

(iii) approved an application for cancellation of removal or suspension of deportation; or

(iv) found that a pending petition or application establishes "prima facie" (true and valid) case for approval; and

(d) the non-citizen has been battered or subjected to extreme cruelty in the US by a spouse or parent, or by a member of the spouse or parent's family residing in the same household as the abused non-citizen and the spouse or parent of the abused non-citizen consented to, or acquiesced in such battery or cruelty; or

(e) the non-citizen has a child who has been battered or subjected to extreme cruelty in the US by the non-citizen's spouse or parent, as long as the non-citizen does not actively participate in the battery or cruelty; or an non-citizen whose child is battered or subjected to extreme cruelty by a member of the non-citizen's spouse or parent's family residing in the same household and the non-citizen's spouse or parent consented or acquiesced to such battery or cruelty; or

(f) the non-citizen is a child who resides in the same household as a parent who has been battered or subjected to extreme cruelty in the US by the parent's spouse or by a member of the spouse's family residing the same household and the non-citizen's spouse consented or acquiesced to such battery or cruelty.

(9) U.S. citizen: means, but may not be limited to:

(a) a person born in the United States;

(b) a person born in Puerto Rico, Guam, U.S. Virgin Islands or northern Mariana Islands who has not renounced or otherwise lost his or her citizenship;

(c) a person born outside the U.S. to at least one U.S. citizen parent; or

(d) a person who is a naturalized citizen.

C. Aliens who are eligible to participate: An alien who meets the definition of a qualified alien shall be eligible to participate in the NMW cash assistance program if the alien:

(1) physically entered the U.S. prior to August 22, 1996 and obtained qualified alien status before August 22, 1996;

(2) physically entered the U.S. prior to August 22, 1996, obtained qualified alien status on or after August 22, 1996 and has continuously lived in the U.S. from the latest date of entry prior to August 22, 1996 until the date the individual obtained qualified alien status;

(3) physically entered the U.S. on or after August 22, 1996, meets the defini-

tion of a qualified alien and has been in qualified alien status for at least five years (five year bar);

(4) physically entered the U.S. before August 22, 1996 and did not continuously live in the U.S. from the latest date of entry prior to August 22, 1996 until obtaining qualified alien status, but has been in qualified alien status for at least five years;

(5) is a lawfully admitted permanent resident alien under the INA, who has worked or can be credited with 40 qualifying quarters; or

(6) is a veteran of the military with an honorable discharge that is not based on alien status who has fulfilled the minimum active duty requirements; or the non-citizen who is on active duty military service; or the person is the spouse, surviving spouse who has not remarried, or an unmarried dependent child of a veteran or active duty service member; and

(7) an alien is eligible for a period of five years from the date an alien:

(a) is granted status as an asylee under section 208 of the INA;

(b) is admitted as a refugee to the U.S. under section 207 of the INA;

(c) has had his or her deportation is withheld under section 241(b)(3) or 243(h) of the INA;

(d) is admitted as an Amerasian immigrant under section 584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act of 1988; or

(e) is admitted as a Cuban or Haitian entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980.

D. Victim of severe form of trafficking: A victim of a severe form of trafficking, regardless of immigration status, who has been certified by the U.S. department of health and human services (DHHS), office of refugee resettlement (ORR), is eligible to the same extent as a refugee.

(1) The date of entry for a victim of trafficking is the date of certification by ORR (which appears in the body of the eligibility letter from the ORR).

(2) A victim of a severe form of trafficking:

(a) must have and present a certification of eligibility letter from ORR for adults or letter for children (similar to but not necessarily a certification letter) as proof of status; and

(b) is not required to provide any immigration documents, but may have such documents and may present such documents.

(3) Determining eligibility for a victim of trafficking must include a call to the trafficking verification line at 1-866-401-5510.

(4) The caseworker must inform ORR of the benefits for which the victim of trafficking has applied.

E. Quarters of coverage:

(1) SSA reports quarters of coverage through the quarters of coverage history system (QCHS).

(2) The number of qualifying quarters is determined under title II of the Social Security Act, including qualifying quarters of work not covered by title II of the Social Security Act, and is based on the sum of: quarters the alien worked; quarters credited from the work of a parent of the alien before the alien became 18 (including quarters worked before the alien was born or adopted); and quarters credited from the work of a spouse of the alien during their marriage if they are still married or the spouse is deceased.

(a) A spouse may not get credit for quarters of a spouse when the couple divorces prior to a determination of eligibility.

(b) If eligibility of an alien is based on the quarters of coverage of the spouse, and then the couple divorces, the alien's eligibility continues until the next recertification. At that time, the caseworker shall determine the alien's eligibility without crediting the alien with the former spouse's quarters of coverage.

(3) Disputing quarters: If an individual disputes the SSA determination of quarters of coverage, the individual may not participate based on having 40 qualifying quarters until a determination is made that the individual can be credited with 40 qualifying quarters. The individual may participate as a state-funded benefit group member, if otherwise eligible.

(4) Federal means-tested benefit: After December 31, 1996, a quarter in which an alien received any federal means-tested public benefit, as defined by the agency providing the benefit shall not be credited toward the 40-quarter total. A parent's or spouse's quarter is not creditable if the parent or spouse actually received any federal means-tested public benefit. If the alien earns the 40th quarter of coverage prior to applying for a federal means- tested public benefit in that same quarter, the caseworker shall allow that quarter toward the 40 qualifying quarters total.

F. Verification of citizenship/eligible alien status: U.S. citizenship is verified only when client statement of citizenship is inconsistent with statements made by the applicant or with other information on the application, previous applications, or other documented information known to HSD.

(1) Questionable U.S. citizenship: Any mandatory benefit group member whose U.S. citizenship is questionable is ineligible to participate until proof of U.S. citizenship is obtained. The member whose citizenship is questionable shall have all of his resources and a pro rata share of income considered available to any remaining benefit group members.

(2) Eligible alien status: Verification of eligible alien status is mandatory at initial certification. Only those benefit group members identified as aliens with qualified and eligible alien status are eligible to participate in the NMW program.

(3) Ineligible or questionable alien status: Any household member identified as an ineligible alien, or whose alien status is questionable cannot participate in the NMW program.

G. Need for documentation:

(1) Benefit group members identified as aliens must present documentation, such as but not limited to, a letter, notice of eligibility, or identification card which clearly establishes that the alien has been granted legal status.

(2) A caseworker shall allow an alien a reasonable time to submit acceptable documentation of eligible alien status. A reasonable time shall be ten days after the date the caseworker requests an acceptable document, or until the 30th day after application, whichever is longer.

(3) If verification of an individual's eligible status is not provided by the deadline, the eligibility of the remaining benefit group members shall be determined. Verification of eligible alien status provided at a later date shall be treated as a reported change in benefit group membership.

(4) During the application process, if an individual has been determined to be a qualified alien and either the individual or HSD submits a request to a federal agency for documentation to verify eligible alien status, HSD must certify the individual in the TANF benefit group as a state-funded participant until a determination is made that the individual is eligible for TANF funded cash assistance.

(5) Inability to obtain INS documentation: If a benefit group indicates an inability to provide documentation of alien status for any mandatory member of the benefit group, that member shall be considered an ineligible alien. The caseworker shall not continue efforts to contact INS when the alien does not provide any documentation from INS.

H. Failure to cooperate: If a benefit group or a benefit group member indicates an unwillingness to provide documentation of alien status for any member, that member shall be considered an ineligible alien. The caseworker shall not

continue efforts to get documentation.

I. Reporting undocumented (illegal) non-citizens: Reporting undocumented non-citizens is a requirement in the TANF program only if the department knows that non-citizen is not lawfully present in the U.S.

(1) HSD must inform the local INS office immediately when a determination is made that any mandatory member of a benefit group is present in the U.S. in violation of the INA. A determination that a non-citizen is in the US in violation of the INA is made when:

(a) there has been a finding or conclusion of law through a formal determination process by the INS or the executive office of immigration review (EOIR) that the non-citizen is unlawfully residing in the US; or

(b) the immigrant states to the department that he or she is in the US in violation of the INA, and the statement is supported by an INS or EOIR finding.

(2) An non-citizen who resides in the US in violation of the INA shall be considered an ineligible benefit group member until there is a finding or conclusion of law through a formal determination process by the INS or EOIR.

(3) Illegal non-citizen status is considered reported when the caseworker enters relevant information about the non-citizen on the benefit group's computer file.

J. Income and resources of ineligible aliens: All the resources and a prorated share of income of an ineligible alien, or of an alien whose alien status is unverified, shall be considered in determining eligibility and the cash assistance benefit amount for the remaining eligible benefit group members.

[8.102.410.10 NMAC - Rp 8.102.410.10 NMAC, 07/01/2001; A, 07/01/2004]

8.102.410.12 NONCONCURRENT RECEIPT OF ASSISTANCE

A. To be eligible for inclusion in a NMW [~~or GA~~] benefit group, the individual cannot already be included in or receiving benefits from:

(1) another department cash assistance benefit group;

(2) an SSI grant;

(3) a tribal TANF program or BIA-GA program;

(4) a government-funded adoption subsidy program;

(5) a TANF program in another state.

B. An individual may not be the payee for more than one NMW cash assistance payment.

C. Supplemental security income:

(1) Ongoing SSI eligibility: A person eligible for SSI on an ongoing basis is not eligible for NMW [~~, GA,~~] or refugee assistance benefits on the basis of concurrent receipt of assistance. The SSI recipient is not included in the benefit group for purposes of financial assistance eligibility and benefit calculation. The income, resources, and needs of the SSI recipient are excluded in determining benefit group eligibility and payment.

(2) SSI applicants: An individual receiving cash assistance benefits from the department may apply for and receive SSI benefits for the same months for which the department has already issued benefits. Cash assistance benefits issued by the department are considered in determining the amount of retroactive SSI benefits. NMW ineligibility or overpayments shall not be established for any month for which SSI issues a retroactive benefit. When notice is received that a benefit group member is approved for SSI on an ongoing basis, that member shall be immediately removed from the benefit group.

[~~**(3) Retroactive SSI payments:**~~

~~**(a)** Retroactive SSI payments are reimbursable under General Assistance program Interim Assistance Reimbursement (IAR) provisions set forth in Paragraph (3) of Subsection B of 8.102.420.16 NMAC.~~

~~**(b)** There may be some situations in which only retroactive SSI benefits are approved. Such approvals do not result in ineligibility due to concurrent receipt of assistance, since the SSI benefits will not be received on an ongoing basis, but they may result in ineligibility on the basis of resources. See 8.102.510.8 NMAC.~~

~~**(4)** Receipt of SSI is a requirement for receiving Adult Residential Shelter Care payments. See Subsection C of 8.102.420.17 NMAC.~~]

D. Subsidized adoptions: Children in receipt of state or federal adoption subsidy payments are included as benefit group members, and their income is counted in determining eligibility and payment.

E. Other department programs: Non-concurrent receipt of assistance limitations apply to departmental programs authorized in 8.102 NMAC and SSI. The food stamp program, medicaid, LIHEAP and other similar programs are not considered concurrent assistance and shall not make an individual ineligible for cash assistance and tribal TANF programs.

[8.102.410.12 NMAC - Rp 8.102.410.12 NMAC, 07/01/2001; A, 07/01/2004]

NEW MEXICO HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

This is an amendment to 8.102.610 NMAC, Section 11. The diversion payment is reduced to $1,000 and clarification is added on eligibility for and issuance of a diversion payment.

8.102.610.11 DIVERSION PAYMENTS TO A NMW BENEFIT GROUP

A. [~~During the initial application interview, the caseworker shall explain to and screen an applicant for eligibility for a diversion payment.~~] The diversion payment is a lump sum payment, which will alleviate a specific need and enable the applicant to keep job or to accept a bona fide offer of employment.

(1) An applicant for NMW cash assistance who meets all NMW eligibility criteria may volunteer to accept a NMW diversion payment for a specific need in lieu of monthly cash assistance payments meant to meet basic needs.

(2) The caseworker shall explain the diversion program and screen the applicant for eligibility for a diversion payment.

(3) The caseworker must ensure that monthly cash assistance is not needed to meet the ongoing needs of the benefit group, either because there is a bona fide job offer or employment.

B. Limitations and amount of a diversion payment:

(1) An applicant may receive a diversion payment a maximum of two times during an individual's 60-month term limit.

(2) The 60-month term limit began on July 1, 1997 for any adult or minor head of the benefit group, or spouse of the minor, who received TANF-funded cash assistance on July 1, 1997, or began or will begin in any month after July 30, 1997. The acceptance of a diversion payment does not reduce the number of months in an individual's 60-month term limit; however, a diversion payment may be authorized only two times once the 60-month term limit begins.

(3) The amount of the diversion payment in all cases shall be [~~$1,500.00~~] $1,000.00.

(4) The authorization and issuance of a diversion payment for a benefit group that has never received TANF cash assistance begins the 60-month term limit for purposes of the two-time maximum diversion payment allowance, not for purposes of counting months of eligibility against the TANF 60-month term limit.

C. Eligibility criteria:

(1) Initial application: Eligibility for a diversion payment shall be limited to an applicant making an initial

application for cash assistance. Initial application shall not include a NMW cash assistance case which is within a six-month mandatory closure because of a third sanction. For the purposes of diversion payments, an initial applicant is one who has never received cash assistance, or one whose cash assistance case has been closed for one or more calendar months.

(2) NMW eligibility is established: Eligibility for a diversion payment shall be based on all eligibility criteria for the NMW cash assistance program.

(a) The applicant must be otherwise eligible for NMW cash assistance, except that the applicant demonstrates that monthly cash assistance to meet basic needs is not required by the benefit group because there is a means of financial support, and the applicant chooses to accept a diversion payment in lieu of cash assistance to meet ongoing needs.

(b) An applicant who cannot demonstrate that monthly cash assistance to meet basic needs is not needed shall not be eligible for a diversion payment.

(3) Specific need: The applicant must make an informed choice whether cash assistance is needed to meet a specific need or basic needs based on information provided by the caseworker. The applicant may demonstrate a need for a specific item or type of assistance which will allow the applicant to keep a job or accept a bona fide offer of employment. Such assistance includes, but is not limited to, cash, support services, housing, transportation, car repairs, and uniforms.

(4) Eligibility for support services: A recipient of a diversion payment shall remain eligible for support services such as child care and transportation. A referral to the NMW work program service provider and to CYFD shall [~~made~~] be made after the applicant signs the agreement to accept a diversion payment and payment is authorized. The applicant shall remain eligible for support services until the end of the 12-month lockout period, until case closure is requested, or the applicant moves out of the state.

(5) Verification and documentation:

(a) The applicant shall be required to provide verification of the specific item or type of assistance which will allow the applicant to keep a job or accept a bona fide offer of employment.

(b) The caseworker shall be required to determine whether the verification provided of the need for a specific item or type of assistance will allow the applicant to keep a job or accept bona fide offer of employment, and must ensure that the amount of the required assistance does not exceed [~~$1500.00~~] $1,000.00.

(c) Documentation shall be required to establish that a diversion payment may be authorized in lieu of cash assistance to meet ongoing needs.

D. Cash assistance lockout period:

(1) Acceptance of a diversion payment: An applicant who accepts a diversion payment shall be prohibited from participating in the NMW cash assistance program for a period of 12 months beginning in the month the diversion payment is authorized.

(2) Receipt of a diversion payment from another state: An applicant who has accepted a diversion payment in any other state shall be prohibited from receiving NMW cash assistance or a diversion payment in New Mexico for a period of 12 months, beginning in the month the diversion payment in the other state was authorized, or for the length of the lockout period in the other state, whichever is shorter.

E. Terms and conditions for receipt of a [~~diversionary~~] diversion payment:

(1) An applicant may accept a diversion payment under the following conditions:

(a) does not need long-term cash assistance to meet basic needs, [~~as determined by the applicant~~] which can be shown by verification of a bona fide offer of employment or employment itself;

(b) demonstrates the need for and verifies a specific item or type of assistance;

(c) enters into a written agreement that defines the terms and expectations of the diversion grant; documents the reason why cash assistance to meet basic needs is not required; identifies the need for a specific type of short-term assistance; and describes the support services available to diversion recipients.

(2) An applicant shall agree not to apply for further cash assistance in New Mexico for a period of 12 months, beginning with the month in which the diversion payment is authorized, or for the length of the lockout period in another state, whichever is shorter.

(3) If the amount needed to meet the specific need is more than the [~~maximum~~] diversion payment, [~~it shall be determined whether the maximum payment will alleviate the specific need; if not, the diversion payment shall not be authorized~~] a determination shall be made whether the diversion payment alone will alleviate the specific need. If not, then the diversion payment cannot be authorized, unless the applicant can provide documentation that demonstrates there is another financial source that, when combined with the diversion payment, will alleviate the specific need.

(4) A recipient of a diversion payment is not required to comply with work program or child support enforcement requirements.

(5) [~~The 60-month term limit does not apply to a recipient of a diversion payment who complies with the terms of the signed agreement~~] Receipt of a diversion payment does not count toward the TANF 60-month term limit for any adult included in the benefit group, unless the benefit group also receives monthly TANF cash assistance during the period covered by the diversion payment.

F. Applying for cash assistance during the lockout period:

(1) An applicant who determines that he is unable to adhere to the terms and conditions for receipt of a diversion payment may apply for cash assistance to meet ongoing basic needs.

(2) A pro rata share of the diversion payment is considered an overpayment. The diversion payment shall be divided over the lockout period and an overpayment calculated beginning from the date of approval of NMW cash assistance until the end of the lockout period.

(3) An overpayment shall not be calculated if it is determined that there is good cause for an application for cash assistance during the lockout period. Good cause includes, but is not limited to, loss of employment, but not a voluntary quit; catastrophic illness or accident of a family member which requires an employed individual to leave employment; a victim of domestic violence; or another situation or emergency that renders an employed family member unable to care for the basic needs of the family. The waiver of the overpayment shall be made on an individual basis and shall be verified and documented.

G. Effect of diversion on other programs:

(1) The receipt of a diversion payment shall be excluded from both income and resource considerations in the medicaid program.

(2) Categorical eligibility is extended to the food stamp benefit group for the lockout period, unless the benefit group requests closure or moves out of New Mexico.

(3) An applicant who accepts a diversion payment shall be eligible for TANF funded child care assistance for the lockout period, unless the benefit group requests closure or moves out of New Mexico.

[8.102.610.11 NMAC - Rp 8.102.610.11 NMAC, 07/01/2001; A, 07/01/2004]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

8 NMAC 4.MAD.718.2, Podiatry Services is being repealed effective July 1, 2004. It will be replaced by 8.310.11 NMAC, Podiatry Services effective July 1, 2004.

8 NMAC 4.MAD.738 is being repealed effective July 1, 2004. It will be replaced by 8.315.4 NMAC effective July 1, 2004.

8.305.1 NMAC is being repealed effective July 1, 2004. It will be replaced by 8.305.1 NMAC effective July 1, 2004.

8.305.2 NMAC is being repealed effective on July 1, 2004. It will be replaced by 8.305.2 NMAC effective July 1, 2004.

8.305.3 NMAC is being repealed effective on July 1, 2004. It will be replaced by 8.305.3 NMAC effective July 1, 2004.

8.305.5 NMAC is being repealed effective July 1, 2004. It will be replaced by 8.305.5 NMAC, effective July 1, 2004.

8.305.7 NMAC is being repealed effective July 1, 2004. It will be replaced by 8.305.7 NMAC effective July 1, 2004.

8.305.9 NMAC is being repealed effective on July 1, 2004. It will be replaced by 8.305.9 NMAC effective July 1, 2004.

8.305.12 NMAC is being repealed effective July 1, 2004. It will be replaced by 8.305.12 NMAC, effective July 1, 2004.

8.305.15 NMAC is being repealed effective on July 1, 2004. It will be replaced by 8.305.15 NMAC, effective July 1, 2004.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 1 GENERAL PROVISIONS

8.305.1.1 ISSUING AGENCY: Human Services Department
[8.305.1.1 NMAC - Rp 8.305.1.1 NMAC, 7-1-04]

8.305.1.2 SCOPE: This rule applies to the general public.
[8.305.1.2 NMAC - Rp 8.305.1.2 NMAC, 7-1-04]

8.305.1.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.305.1.3 NMAC - Rp 8.305.1.3 NMAC, 7-1-04]

8.305.1.4 DURATION: Permanent
[8.305.1.4 NMAC - Rp 8.305.1.4 NMAC, 7-1-04]

8.305.1.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.305.1.5 NMAC - Rp 8.305.1.5 NMAC, 7-1-04]

8.305.1.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid managed care program.
[8.305.1.6 NMAC - Rp 8.305.1.6 NMAC, 7-1-04]

8.305.1.7 DEFINITIONS: The state of New Mexico is committed to improving the health status of New Mexico residents whose health care services are funded by the Title XIX (medicaid) program. As a means of improving health status, a capitated managed care plan has been implemented. This section contains the glossary for the New Mexico medicaid managed care policy. The following definitions apply to terms used in this chapter.

A. **Abuse:** Provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary cost to medicaid, in reimbursement for services that are not medically necessary, or in services that fail to meet professionally recognized standards for health care. Abuse also includes client or member practices that result in unnecessary costs to medicaid.

B. **Action:** The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, modification or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure to provide services in a timely manner. An untimely service authorization constitutes a denial and is thus considered an action.

C. **Appeal:** A request from a member or provider for review by the managed care organization (MCO) of an MCO action.

D. **Approvals:** Approvals are either initial or concurrent review decisions, which yield utilization management authorizations based on the client meeting the clinical criteria for the requested medicaid service(s) and/or level of care.

E. **Assignment algorithm:** A mathematically weighted predetermined method for assigning MCO mandatory enrollees who do not select an MCO.

F. **Behavioral health:** Refers to mental health and substance abuse.

G. **Benefit package:** Medicaid covered services that must be furnished by the MCO and for which payment is included in the capitation rate.

H. **Capitation:** A per-member, monthly payment to an MCO that covers contracted services and is paid in advance of service delivery.

I. **Care coordination:** Is a service to assist members with special health care needs, on an as needed basis. It is member-centered, family-focused when appropriate, culturally competent and strength-based. Care coordination can help to ensure that the medical and behavioral health needs of the Salud! population are identified and services are provided and coordinated with the individual member and family if appropriate. Care coordination operates within the MCO with a dedicated care coordination staff, functioning independently, but is structurally linked to the other MCO systems, such as quality assurance, member services, and grievances.

J. **Case:** A household that medicaid treats as a unit for purposes of eligibility determination; for example, a parent and child; a legal guardian and child; or a set of siblings.

K. **Children with special health care needs (CSHCN):** Individuals under 21 years of age, who have, or are at an increased risk for, a chronic physical, developmental, behavioral or emotional condition, and who also require health and related services of a type or amount beyond that required by children generally.

L. **Clean claim:** A manually or electronically submitted claim from a participating provider that contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside the health plan's system. A clean claim may include errors originating in the state's system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. A clean claim is not materially deficient or improper, such as lacking substantiating documentation currently required by the health plan, or has no

particular or unusual circumstances requiring special treatment that prevents payment from being made by the health plan within 30 days of the date of receipt if submitted electronically or 45 days if submitted manually.

M. **Client:** An individual who has applied for and been determined eligible for Title XIX (medicaid).

N. **CMS:** Centers for medicare and medicaid services.

O. **Community-based care:** A system of care, which seeks to provide services to the greatest extent possible, in or near the member's home community.

P. **Continuous quality improvement (CQI):** CQI is a process for improving quality that assumes opportunities for improvement are unlimited; is customer-oriented, data driven, and results in implementation of improvements; and requires continual measurement of implemented improvements and modification of improvements, as indicated.

Q. **Cultural competence:** Cultural competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals, that enables them to work effectively in cross-cultural situations. Cultural competency involves the integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques and marketing programs that match an individual's culture and increase the quality and appropriateness of health care and outcomes.

R. **Delegation:** A formal process by which an MCO gives another entity the authority to perform certain functions on its behalf. The MCO retains full accountability for the delegated functions.

S. **Denial-administrative/technical:** A denial of authorization requests due to the requested procedure, service or item not being covered by medicaid or due to provider noncompliance with administrative policies and procedures established by either the Salud! MCO or the medical assistance division, except pharmaceutical services which the formulary process covers.

T. **Denial-clinical:** A non-authorization decision at the time of an initial request for a medicaid service based on the client not meeting medical necessity for the requested service, except pharmaceutical services which are covered by the formulary process. The utilization management (UM) staff may recommend an alternative service, based on the client's need for a lower level of service. If the requesting provider accepts this alternative service, it is considered a new request for the alternative service and a clinical denial of the original service request.

U. **Disenrollment, MCO initiated**: When requested by an MCO for substantial reason, removal of a medicaid member from membership in the requesting MCO, as determined by HSD, on a case-by-case basis.

V. **Disenrollment, member initiated (switch)**: When requested by a member for substantial reason, transfer of a medicaid member as determined by HSD on a case-by-case basis, from one Salud! MCO to a different Salud! MCO during a member lock-in period.

W. **Durable medical equipment (DME):** Equipment that can withstand repeated use, is primarily used to serve a medical purpose, is not useful to individuals in the absence of an illness or injury and is appropriate for use at home.

X. **Emergency:** An emergency condition is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part.

Y. **Encounter:** The record of a physical or behavioral health service rendered by a provider to an MCO member.

Z. **Enrollee:** A medicaid recipient who is currently enrolled in a managed care organization in a given managed care program.

AA. **Enrollment:** The process of enrolling eligible clients in an MCO for purposes of management and coordination of health care delivery.

BB. **Exempt:** The enrollment status of a client who is not mandated to enroll in managed care.

CC. **Exemption:** Removal of a medicaid member from mandatory enrollment in Salud! and placement in the medicaid fee-for-service program. Such action is only for substantial reason, as determined by HSD on a case-by-case basis.

DD. **External quality review organization (EQRO)**: An independent organization with clinical and health services expertise that is capable of reviewing health care delivery systems and their internal quality assurance mechanisms.

EE. **Family-centered care:** When a child is the patient, the system of care reflects the importance of the family or legal guardian in the way services are planned and delivered. Family-centered care facilitates collaboration between family members and medical professionals builds on individual and family strengths and respects diversity of families.

FF. **Family planning services:** Services provided to members of childbearing age to temporarily or permanently prevent or delay pregnancy (see MAD-762, *Reproductive Health Services*).

GG. **Fee-for-service (FFS):** The traditional medicaid payment method whereby payment is made by HSD to a provider after services are rendered and billed.

HH. **Fraud:** An intentional deception or misrepresentation made by an entity or person, including but not limited to, an MCO, subcontractor, provider or client with the knowledge that the deception could result in some unauthorized benefit to himself or to some other previously described entity or person. It includes any act that constitutes fraud under applicable federal or state law.

II. **Full risk contracts:** Contracts that place the MCO at risk for furnishing or arranging for comprehensive services.

JJ. **Gag order:** Subcontract provisions or MCO practices, either written, oral or implied, that effectively prevent a provider from furnishing accurate or complete information to members about options for diagnosis or treatment of physical, mental or behavioral illness, injury, or condition; or prevent a provider from talking to the member or HSD about the MCO or its business practices.

KK. **Grievance (member):** Oral or written statement by a member expressing dissatisfaction with any aspect of the MCO or its operations that is not an MCO action.

LL. **Grievance (provider):** Oral or written statement by a provider to the MCO regarding utilization management decisions and/or provider payment issues.

MM. **HCFA:** Health care financing administration. Effective 2001, now known as CMS, centers for medicare and medicaid services.

NN. **Health plan:** A health maintenance organization (HMO), managed care organization (MCO), or third party payer or their agents.

OO. **HIPAA:** Health Insurance Portability and Accountability Act of 1996.

PP. **Hospitalist:** A physician employed by a hospital to manage the care of a member admitted to the hospital for inpatient care.

QQ. **Human services department (HSD):** The sole executive department in New Mexico responsible for the administration of Title XIX (medicaid). "HSD" may also indicate the department's designee, as applicable.

RR. **Claims incurred but not reported (IBNR):** Claims for services authorized or rendered for which the MCO has incurred financial liability, but the claim has not been received by the MCO. This estimating method relies on data from prior authorization and referral systems, as well as other data analysis systems.

SS. **Individuals with special health care needs (ISHCN):** Individuals with ongoing health conditions, high or complex service utilization, or low to severe functional limitations.

TT. **Managed care organization (MCO):** An organization licensed to manage, coordinate and assume financial risk on a capitated basis for the delivery of specified services to enrolled members from a certain geographic area. Also referred to as a managed care plan and managed care program.

UU. **Marketing**: The act or process of promoting a business or commodity. Marketing includes brochures, leaflets, internet, newspaper, magazine, radio, television, billboard materials, MCO yellow page advertisements, and any other presentation materials used by an MCO, MCO representative, or MCO subcontractor to attract or retain medicaid enrollment.

VV. **MCO appeal (member):** A request from a member or a provider, with the member's written consent, for review by the managed care organization (MCO) of an MCO action. An "MCO appeal" should not be confused with an applicant's or recipient's right to appeal an HSD fair hearing decision to state district court under the Public Assistance Appeals Act, NMSA 1978, Section 27-3-4 and pursuant to NMSA 1978, Section 39-3-1.1.

WW. **MCO mandatory enrollee:** A client whose enrollment into an MCO is mandated.

XX. **Medicaid:** The medical assistance program authorized under Title XIX of the Social Security Act or its successors, furnished to New Mexico residents who meet specific eligibility requirements.

YY. **Medical home:** A conceptual model that facilitates the provision of quality care that is accessible, family-centered, continuous, coordinated, compassionate and culturally competent.

ZZ. **Medically necessary services**:

(1) Medically necessary services are clinical and rehabilitative physical, mental or behavioral health services that:

(a) are essential to prevent, diagnose or treat medical conditions or are essential to enable the individual to attain, maintain or regain functional capacity;

(b) are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical, mental and behavioral health care needs of the individual;

(c) are provided within professionally accepted standards of practice and national guidelines; and

(d) are required to meet the physical, mental and behavioral health needs of the individual and are not primarily for the convenience of the individual, the provider or the payer.

(2) Application of the definition:

(a) a determination that a health care service is medically necessary does not mean that the health care service is a covered benefit or an amendment, modification or expansion of a covered benefit;

(b) the MCO making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the medicaid benefit package applicable to an eligible individual shall do so by:

(i) evaluating individual physical, mental and behavioral health information provided by qualified professionals who have personally evaluated the individual within their scope of practice, who have taken into consideration the individual's clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training, as appropriate;

(ii) considering the views and choices of the individual or the individual's legal guardian, agent or surrogate decision maker regarding the proposed covered service as provided by the clinician or through independent verification of those views; and

(iii) considering the services being provided concurrently by other service delivery systems;

(c) physical, mental and behavioral health services shall not be denied solely because the individual has a poor prognosis. Required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible individual solely because of the diagnosis, type of illness or condition; and

(d) decisions regarding benefit coverage for children shall be governed by the EPSDT coverage rules.

AAA. **Member:** A client enrolled in an MCO.

BBB. **Member month:** A calendar month during which a member is enrolled in an MCO.

CCC. **National committee for quality assurance (NCQA):** A private national organization that develops quality standards for managed health care.

DDD. **Network provider:** An individual provider, clinic, group, association or facility employed by or contracted with an MCO to furnish medical or behavioral health services to the MCO's members under the provisions of the medicaid managed care contract.

EEE. **Pend decision:** A prior authorization decision is considered pended when the decision is delayed due to lack of documentation, inability to contact parties involved or other reason which delays finalizing an approval. A decision by an MCO to pend approval does not extend or modify required utilization management decision timelines.

FFF. **Potential enrollee:** A medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO.

GGG. **Pregnancy-related services:** Medically necessary medical or surgical services related to pregnancy, including procedures to terminate pregnancy.

HHH. **Primary Care:** All health services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, physician assistant or certified nurse practitioner.

III. **Primary Care Case Management (PCCM):** A medical care model in which clients are assigned to a primary care provider who is responsible for managing the quality, appropriateness, and efficiency of the care they receive. The primary care provider is responsible for furnishing case management services to medicaid eligible recipients that include the location, coordination, and monitoring of primary health care services and the appropriate referral to specialty care services.

JJJ. **Primary care case manager :** A physician, a physician group practice, an entity that medicaid-eligible recipients employs or arranges with physicians to furnish primary care case management services or, at state option, any of the following:

(1) a physician assistant;

(2) a nurse practitioner; or

(3) a certified nurse mid-wife.

KKK. **Primary care provider (PCP):** A provider who agrees to manage and coordinate the care provided to members in the managed care program.

LLL. **Rate cell:** A combination of category of eligibility and demo-

graphics used to isolate utilization patterns for the determination of capitation.

MMM. **Received but unpaid claims (RBUC):** Claims received by the MCO but not paid affecting appropriate expense and aging accounting categories. Such claims are counted as of the date of receipt by the MCO.

NNN. **Reduction of care:** A utilization management staff authorization of the type of service requested by the provider but in lesser amounts or units of service, based on the client's medical need, than was originally requested, except pharmaceutical services which are covered by the formulary process.

OOO. **Referral:** Any specialty, inpatient, outpatient, or diagnostic services that a physician or physician group orders or arranges, but does not provide directly.

PPP. **Reinsurance:** Reinsurance is a proactive financial tool which may be used by an MCO to minimize exposure to losses incurred when members utilize health care services beyond anticipated levels or overall member utilization is greater than expected.

QQQ. **Risk:** The possibility that revenues of the MCO will not be sufficient to cover expenditures incurred in the delivery of contractual services.

RRR. **Routine care:** All care, which is not emergent or urgent.

SSS. **Subcontract:** A written agreement between the MCO and a third party, or between a subcontractor and another subcontractor, to provide services.

TTT. **Subcontractor:** A third party who contracts with the MCO or an MCO subcontractor for the provision of services.

UUU. **Terminations of care:** The utilization management review decision made during a concurrent review, which yields a denial, based on the current service being no longer medically necessary, except pharmaceutical services, which are covered by the formulary process.

VVV. **Third party:** An individual entity or program, which is or may be, liable to pay all or part of the expenditures for medicaid members for services furnished under a state plan.

WWW. **Urgent condition:** Acute signs and symptoms, which, by reasonable medical judgment, represent a condition of sufficient severity such that the absence of medical attention within 24 hours could reasonably be expected to result in an emergency condition.

[8.305.1.7 NMAC - Rp 8.305.1.7 NMAC, 7-1-04]

8.305.1.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.

[8.305.1.8 NMAC - Rp 8.305.1.8 NMAC, 7-1-04]

HISTORY OF 8.305.1 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:

8 NMAC 4.MAD.606.1.1, Managed Care Policies, Definitions, 6-19-97.

History of Repealed Material:

8 NMAC 4.MAD.606.1.1, Managed Care Policies, Definitions - Repealed, 7-1-01.

8.305.1 NMAC, General Provisions - Repealed 7-1-04.

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 2 MEMBER EDUCATION

8.305.2.1 ISSUING AGENCY: Human Services Department

[8.305.2.1 NMAC - Rp 8.305.2.1 NMAC, 7-1-04]

8.305.2.2 SCOPE: This rule applies to the general public.

[8.305.2.2 NMAC - Rp 8.305.2.2 NMAC, 7-1-04]

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

[8.305.2.3 NMAC - Rp 8.305.2.3 NMAC, 7-1-04]

8.305.2.4 DURATION: Permanent

[8.305.2.4 NMAC - Rp 8.305.2.4 NMAC, 7-1-04]

8.305.2.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.

[8.305.2.5 NMAC - Rp 8.305.2.5 NMAC, 7-1-04]

8.305.2.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid managed care program.

[8.305.2.6 NMAC - Rp 8.305.2.6 NMAC, 7-1-04]

8.305.2.7 DEFINITIONS: See 8.305.1.7 NMAC.

[8.305.2.7 NMAC - Rp 8.305.2.7 NMAC, 7-1-04]

8.305.2.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.

[8.305.2.8 NMAC - Rp 8.305.2.8 NMAC, 7-1-04]

8.305.2.9 MEMBER EDUCATION: Medicaid clients must be educated about their rights, responsibilities, service availability and administrative roles under the managed care program. Client education is initiated when a client becomes eligible for medicaid and is augmented by information provided by HSD and the managed care organization (MCO).

A. **Initial information:** The education of the client is initiated by the eligibility determination agencies. HSD distributes information about medicaid managed care and the enrollment process to these agencies.

B. **MCO enrollment information:** Once a client is determined to be an MCO mandatory enrollee, HSD will provide to the client information about services included in the MCO benefit package, and the MCOs from which the client can choose to enroll as a member.

C. **Informational materials:** The MCO is responsible for providing members and potential members, upon request, a member handbook and a provider directory. The member handbook and the provider directory shall be available in formats other than English. If there is a prevalent population of 5% within the MCO membership, as determined by the MCO or HSD, these materials shall be made available in the language of the identified prevalent population.

(1) The member handbook must include the following:

(a) MCO demographic information, including the organization's hotline telephone number;

(b) information on how to obtain services such as after-hours and emergency services, including the 911 telephone system or its local equivalent;

(c) patient bill of rights and member responsibilities, including any restrictions on the member's freedom of choice among network providers;

(d) information pertaining to coordination of care by PCPs;

(e) how to obtain care in emergency and urgent conditions;

(f) description of mandatory benefits;

(g) information on accessing behavioral health or other specialty services, including a discussion of the member's rights to self-refer to in-plan and out-of-plan family planning providers and a female member's right to self-refer to a women's health specialist with in the network for covered care;

(h) limitations to the receipt of care from out-of-network providers;

(i) a list of services for which prior authorization or a referral is required and the method of obtaining both;

(j) a policy on referrals for specialty care and other benefits not furnished by the member's PCP;

(k) notice to members about the grievance process and about HSD's fair hearing process;

(l) information on the member's right to terminate enrollment and the process for voluntarily disenrolling from the plan;

(m) information regarding advance directives;

(n) information regarding obtaining a second opinion;

(o) information on cost sharing, if any;

(p) how to obtain information, upon request, determined by HSD as essential during the member's initial contact with the MCO, which may include a request for information regarding the MCO's structure, operation, and physician's incentive plans,

(q) populations excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program; and

(r) benefits under the state medicaid plan which are not covered by the contract and how the member will be able to access those benefits.

(2) The provider directory must include the following:

(a) MCO addresses and telephone numbers;

(b) a listing of primary care and self-refer specialty providers with the identity, location, phone number, and qualifications to include area of special expertise and non-English languages spoken that would be helpful to individuals deciding to enroll; specialty providers for self-referral shall include, but not be limited to, family planning providers, point-of-entry behavioral health providers, urgent and emergency care providers, Indian health service, other Native American providers and pharmacies; and

(c) the material must be available in a manner and format that may be easily understood by all identified prevalent populations.

D. **Other requirements:**

(1) The MCO must provide to enrolled members the member handbook and provider directory within 30 calendar days of enrollment.

(2) The handbook and directory must be provided, in a comprehensive, understandable format that takes into consideration the special needs population, and is in accordance with federal mandates and meets communication requirements delineated in 8.305.8.15 NMAC, *Patient Bill Of Rights*. This information may also be accessible via the internet, and be provided as requested by HSD.

(3) Oral and sign language interpretation must be made available free of charge to members and to potential members, upon request, and be available in all non-English languages.

(4) The member handbook must be approved by HSD prior to distribution to medicaid members.

(5) Notification of material changes in the administration of the MCO, changes to the MCO's provider network, significant changes in applicable state law, and any other information deemed relevant by HSD must be distributed to the members thirty days (30) prior to the intended effective date of the change. In addition, the MCO must make a good faith effort to give written notice of termination of a contracted provider within fifteen days after receipt or issuance of termination notice.

(6) Notification about any of these changes may be made without reprinting the entire handbook.

(7) The MCO must notify all members at least once per year of their right to request and obtain member handbooks and provider directories.

E. **MCO policies and procedures on member education:** The MCO must maintain policies and procedures governing the development and distribution of educational material for members. Policies must address how members and potential members receive information, the means of dissemination and the content comprehension level and languages of this information. The MCO shall have written policies and procedures regarding the utilization of information on race, ethnicity, and primary language spoken by its membership.

F. **Health education:** The MCO must provide a continuous program of health education without cost to members. Such a program may include publications (brochures, newsletters), electronic media (films, videotapes), presentations (seminars, lunch-and-learn sessions) and classroom instruction. HSD shall not approve health education materials. The MCO shall provide programs of wellness education. Additional programs may be provided to address the social, physical, behavioral and emotional consequences of high-risk behaviors.

G. **Maintenance of toll-free line:** The MCO shall maintain one or more toll-free telephone lines which are accessible 24 hours a day, seven days a week, to facilitate member access to a qualified clinical staff to answer health-related questions. MCO members may also leave voice mail messages to obtain other MCO policy information and to register grievances with the MCO. The MCO shall return the telephone call by the next business day.

[8.305.2.9 NMAC - Rp 8.305.2.9 NMAC, 7-1-04]

HISTORY OF 8.305.2 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:

8 NMAC 4.MAD.606.1.2, Managed Care Policies, Member Education, 6-19-97.

History of Repealed Material:

8 NMAC 4.MAD.606.1.2, Managed Care Policies, Member Education - Repealed, 7-1-01.

8.305.2 NMAC, Medicaid Managed Care, Member Education - Repealed 7-1-04.

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 3 CONTRACT MANAGEMENT

8.305.3.1 ISSUING AGENCY: Human Services Department

[8.305.3.1 NMAC - Rp 8.305.3.1 NMAC, 7-1-04]

8.305.3.2 SCOPE: This rule applies to the general public.

[8.305.3.2 NMAC - Rp 8.305.3.2 NMAC, 7-1-04]

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

[8.305.3.3 NMAC - Rp 8.305.3.3 NMAC, 7-1-04]

8.305.3.4 DURATION: Permanent
[8.305.3.4 NMAC - Rp 8.305.3.4 NMAC, 7-1-04]

8.305.3.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.305.3.5 NMAC - Rp 8.305.3.5 NMAC, 7-1-04]

8.305.3.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid managed care program.
[8.305.3.6 NMAC - Rp 8.305.3.6 NMAC, 7-1-04]

8.305.3.7 DEFINITIONS: See 8.305.1.7 NMAC.
[8.305.3.7 NMAC - Rp 8.305.3.7 NMAC, 7-1-04]

8.305.3.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.305.3.8 NMAC - Rp 8.305.3.8 NMAC, 7-1-04]

8.305.3.9 ELIGIBLE MANAGED CARE ORGANIZATIONS (MCO): The human services department (HSD) shall award risk-based contracts to MCOs with statutory authority to assume risk, enter into prepaid capitation agreements and which meet applicable requirements and standards delineated under state and federal law including Title IV of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973 and the Americans with Disabilities Act. The medical and behavioral health services to be delivered under the terms of the risk-based contract are defined in 8.305.7 NMAC, *Benefit Package*.

A. **Procurement process:** HSD shall award risk-based contracts to MCOs using a competitive procurement process that conforms to the terms of the New Mexico Procurement Code. Offerors must submit their responses to the request for proposal in conformity with the requirements specified in the request for proposal.

B. **Contract issuance:** The risk-based contracts shall be awarded for at least a two-year period. Contracts are issued to offerors meeting requirements specified under the terms of the managed care contract.

C. Other methods of payment may be included in the contract such as, but not limited to, point of service reimbursement for specific program requirements.
[8.305.3.9 NMAC - Rp 8.305.3.9 NMAC, 7-1-04]

8.305.3.10 CONTRACT MANAGEMENT: HSD is responsible for management of the managed care contracts issued to MCOs. HSD shall provide the oversight and administrative functions to ensure MCO compliance with the terms of the managed care contract.

A. **General contract requirements:** The MCOs must meet all specified terms of the medicaid managed care contract and the Health Insurance Portability and Accountability Act (HIPAA). This includes, but is not limited to, insuring confidentiality as it relates to medical records and any other health and enrollment information that identifies a particular member. An MCO will be held harmless in conversion to HIPAA electronic transmission formats when delays are the result of implementation issues at HSD.

B. **Subcontracting requirements:** The MCO may subcontract to a qualified individual or organization the provision of any service defined in the benefit package or other required MCO function (except as they relate to the provision of behavioral health services). The MCO shall be legally responsible to HSD for all work performed by any MCO subcontractor. The MCO must submit boilerplate contract language and sample contracts for various types of subcontracts. Any substantive changes to contract templates must be approved by HSD prior to issuance.

(1) **Credentialing requirements:** The MCO shall maintain policies and procedures for verifying that the credentials of its providers and subcontractors meet applicable standards. The MCO shall assure the prospective subcontractor's ability to perform the activities to be delegated.

(2) **Review requirements:** The MCO shall maintain a fully executed original of all subcontracts and make them accessible to HSD on request.

(3) **Minimum requirements:**

(a) subcontracts shall be executed in accordance with applicable federal and state laws, regulations, policies and rules;

(b) subcontracts shall identify the parties of the subcontract and the parties' legal basis of operation in the state of New Mexico;

(c) subcontracts shall include procedures and criteria for terminating the subcontract;

(d) subcontracts shall identify the services to be performed by the subcontractor and the services to be performed under other subcontracts. Subcontracts must describe how members access services provided under the subcontract;

(e) subcontracts shall include reimbursement rates and risk assumption, where applicable;

(f) subcontractors shall maintain records relating to services provided to members for six years;

(g) subcontracts shall require that member information be kept confidential, as defined by federal or state law, and be HIPAA compliant;

(h) subcontracts shall provide that authorized representatives of HSD have reasonable access to facilities, personnel and records for financial and medical audit purposes;

(i) subcontracts shall include a provision for the subcontractor to release to the MCO any information necessary to perform any of its obligations;

(j) subcontractors shall accept payment from the MCO for any services included in the benefit package and cannot request payment from HSD for services performed under the subcontract;

(k) if subcontracts include primary care, provisions for compliance with PCP requirements delineated in the MCO contract with HSD apply;

(l) subcontractors shall comply with all applicable state and federal statutes, rules and regulations, including the prohibition against discrimination;

(m) subcontracts shall have a provision for terminating, rescinding, or canceling the contracts for violation of applicable HSD requirements;

(n) subcontracts shall not prohibit a provider or other subcontractor from entering into a contractual relationship with another MCO;

(o) subcontracts may not include incentives or disincentives that encourage a provider or other subcontractor to not enter into a contractual relationship with another MCO;

(p) subcontracts shall not contain any gag order provisions nor sanctions against providers who assist members in accessing the grievance process or otherwise protecting member's interests; and

(q) subcontracts shall specify the time frame for submission of encounter data to the MCO.

(4) **Excluded providers:** The MCO shall not contract with an individual provider, or an entity, or an entity with an individual who is an officer, director, agent, or manager who owns or has a controlling interest in the entity, who has been convicted of crimes specified in Section 1128 of the Social Security Act, excluded from participation in any other state's medicaid program, medicare, or any other public or private health or health insurance program, assessed a civil penalty under the provision

of Section 1128, or who has a contractual relationship with an entity convicted of a crime specified in Section 1128.

C. **Provider incentive plans:** The MCO shall ensure that direct or indirect incentives offered in the subcontract shall not serve as an inducement to reduce or limit medically necessary services to members.

[8.305.3.10 NMAC - Rp 8.305.3.10 NMAC, 7-1-04]

8.305.3.11 ORGANIZATIONAL REQUIREMENTS:

A. **Organizational structure:** The MCO shall provide the following information to HSD and updates, modifications, or amendments to HSD within 30 days:

(1) current written charts of organization or other written plans identifying organizational lines of accountability;

(2) articles of incorporation, bylaws, partnership agreements, or similar documents that describe the MCO's mission, organizational structure, board and committee composition, mechanisms to select officers and directors and board and public meeting schedules; and

(3) documents describing the MCO's relationship to parent affiliated and related business entities including, but not limited to, subsidiaries, joint ventures or sister corporations.

B. **Policies and procedures:** The MCO shall establish and maintain written policies, procedures and job descriptions as required by HSD. The MCO shall establish, maintain and implement guidelines for developing, reviewing and approving policies, procedures and job descriptions. The MCO shall provide MCO policies, procedures and job descriptions for key personnel and guidelines for review to HSD on request. The MCO shall notify HSD when changes in key personnel occur.

(1) **Review of policies and procedures:** The MCO shall review the MCO's policies and procedures every two years, unless otherwise specified herein, to ensure that they reflect the MCO's current best industry practices. Job descriptions shall be reviewed to ensure that current employee duties reflect written requirements. Modifications or amendments to current policies, procedures or job descriptions of key positions shall be made using the guidelines delineated during the procurement process. Substantive modification or amendment to key positions must be reviewed by HSD.

(2) **Distribution of information:** The MCO shall distribute to providers information necessary to ensure that providers meet all contract requirements.

(3) **Business requirements:** The MCO shall have the administrative, information and other systems in place necessary to fulfill the terms of the medicaid managed care contracts. Any change in identified key MCO personnel shall conform to the requirements of the managed care contract.

(4) **Financial requirements:** The MCO shall meet minimum requirements delineated by federal and state law with respect to solvency and performance guarantees for the duration of the medicaid managed care contract. In addition, the MCO shall meet additional financial requirements specified in the medicaid managed care contract.

(5) **Member services:** The MCO shall have a member services function that coordinates communication with members and acts as a member advocate. Member services shall include sufficient staff to assist members in resolving problems or making inquiries. The MCO's policies and procedures shall be made available on request to members or member representatives for review during normal business hours.

(6) **Consumer advisory board:** The MCO shall establish a consumer advisory board that includes regional representation of members, advocates and providers.

(a) Consumer advisory board members shall serve to advise the MCO on issues concerning service delivery and quality of service, the member bill of rights and member responsibilities, resolution of member grievances and the needs of groups represented by board member as they pertain to medicaid managed care. The board shall meet at least quarterly and keep a written record of meetings. The board roster and minutes shall be made available to HSD on request. The consumer advisory board shall advise HSD ten days in advance of meetings to be held. HSD shall attend and observe the meetings of the board at its discretion.

(b) The MCO shall attend at least two statewide consumer driven or hosted meetings per year, of the MCO's choosing, that focus on consumer issues and needs, to ensure that members' concerns are heard and addressed.

(7) **Contract enforcement:** HSD shall enforce contractual and state and federal regulatory requirements specified in the scope of work of the medicaid managed care contact. HSD may use the following types of sanctions for less than satisfactory or nonperformance of contract provisions:

(a) require plans of correction;

(b) impose directed plans of correction;

(c) impose civil or administrative monetary penalties and fines under the following guidelines:

(i) a maximum of $25,000.00 for each of the following determinations: failure to provide service; misrepresentation or false statements to members, potential members, or health care providers; failure to comply with physician incentive plan requirements; and marketing violations;

(ii) a maximum of $100,000.00 for each of the following determinations: discrimination or misrepresentation or false statements to HSD or CMS;

(iii) a maximum of $15,000.00 for each member HSD determines was not enrolled, or reenrolled, or enrollment was terminated because of a discriminatory practice; this is subject to an overall limit of $100,000.00 under (ii) above;

(iv) a maximum of $25,000.00 or double the amount of the excess charges, whichever is greater, for premiums or charges in excess of the amount permitted under the medicaid program; the state must deduct from the penalty the amount of overcharge and return it to the affected enrollees; and

(d) adjust automatic assignment formula;

(e) rescind marketing consent;

(f) suspend new enrollment, including default enrollment after the effective date of the sanction;

(g) appoint a state monitor, the cost of which shall be borne by the MCO;

(h) deny payment;

(i) assess actual damages;

(j) assess liquidated damages;

(k) remove members with third party coverage from enrollment with the MCO;

(l) allow members to terminate enrollment;

(m) suspend agreement;

(n) terminate MCO contract;

(o) apply other sanctions and remedies specified by HSD; and

(p) impose temporary management only if it finds, through on-site survey, enrollee complaints, or any other means that;

(i) there is continued egregious behavior by the MCO, including but not limited to, behavior that is described in Subparagraph (c) above, or that is contrary to any requirements of 42 USC Sections 1396b(m) or 1396u-2; or

(ii) there is substantial risk to member's health; or

(iii) the sanction is necessary to ensure the health of the MCO's members while improvement is made to remedy violations made under Subparagraph (c) above; or until there is orderly termination or reorganization of the MCO.

(iv) HSD shall not

delay the imposition of temporary management to provide a hearing before imposing this sanction; HSD shall not terminate temporary management until it determines that the MCO can ensure that the sanction behavior will not re-occur; refer to state and federal regulations for due process procedures.
[8.305.3.11 NMAC - Rp 8.305.3.11 NMAC, 7-1-04]

HISTORY OF 8.305.3 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:
8 NMAC 4.MAD.606.2, Managed Care Policies, Contract Management, 6-19-97.

History of Repealed Material:
8 NMAC 4.MAD.606.2, Managed Care Policies, Contract Management - Repealed, 7-1-01.
8.305.3 NMAC, Medicaid Managed Care, Contract Management - Repealed 7-1-04.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 5 ENROLLMENT IN MANAGED CARE

8.305.5.1 ISSUING AGENCY: Human Services Department
[8.305.5.1 NMAC - Rp 8.305.5.1 NMAC, 7-1-04]

8.305.5.2 SCOPE: This rule applies to the general public.
[8.305.5.2 NMAC - Rp 8.305.5.2 NMAC, 7-1-04]

8.305.5.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.305.5.3 NMAC - Rp 8.305.5.3 NMAC, 7-1-04]

8.305.5.4 DURATION: Permanent
[8.305.5.4 NMAC - Rp 8.305.5.4 NMAC, 7-1-04]

8.305.5.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.305.5.5 NMAC - Rp 8.305.5.5 NMAC, 7-1-04]

8.305.5.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid managed care program.
[8.305.5.6 NMAC - Rp 8.305.5.6 NMAC, 7-1-04]

8.305.5.7 DEFINITIONS: See 8.305.1.7 NMAC.
[8.305.5.7 NMAC - Rp 8.305.5.7 NMAC, 7-1-04]

8.305.5.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.305.5.8 NMAC - Rp 8.305.5.8 NMAC, 7-1-04]

8.305.5.9 ENROLLMENT PROCESS.

A. **Enrollment requirements:** The Managed care organization (MCO) shall provide an open enrollment period during which the MCO shall accept eligible individuals in the order in which they apply without restriction, unless authorized by the CMS regional administrator, up to the limits contained in the managed care contract. The MCO shall not discriminate on the basis of health status or a need for health care services. The MCO shall not discriminate against individuals eligible to enroll on the basis of race, color, national origin, or sexual orientation and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, or sexual orientation. All enrollments in a specific MCO shall be client choice.

B. **Selection period:** The client shall have 14 calendar days to select an MCO. If a selection is not made in 14 days, the client shall be assigned to an MCO by HSD.

C. **Enrollment methods when no selection made:**

(1) **Enrollment with previous MCO**: The member is automatically enrolled with the previous MCO unless the MCO is no longer in good standing, is no longer contracting with HSD or has had enrollment suspended.

(2) **Enrollment based on case continuity**: Enrollment based on case continuity is applied in the following manner:

(a) **Processing case continuity**: The client is enrolled with the MCO to which the majority of the case (family) members is assigned. If an equal number of case (family) members are assigned to different MCOs and a majority cannot be identified, the client is assigned to an MCO to which other case (family) members are assigned.

(b) **Newborn enrollment**: A newborn whose mother is a member in an MCO is automatically enrolled in the mother's MCO. The newborn remains enrolled with the mother's MCO until the mother selects a new MCO for the child.

(3) **Percentage-based assignment (assignment algorithm):** As determined by HSD, clients who are not enrolled using the previous methods may be enrolled using a percentage-based assignment process. The percentage-based assignments for each MCO shall be determined based on the MCO's performance in such areas as the quality assurance standards, encounter data submissions, reporting requirements, third party liability collections, marketing plan, community relations, coordination of service, grievance resolution, claims payment, and consumer input.

D. **Begin date of enrollment:** Enrollment begins the first day of the first full month following selection or assignment except in the following circumstances:

(1) newborn enrollment, (Subsection A of 8.305.4.10 NMAC, *newborn enrollment*);

(2) clients in treatment foster care placement, (Subsection C of 8.305.4.10 NMAC, *clients in treatment foster care placements*);

(3) clients receiving hospice care, (Subsection E of 8.305.4.10 NMAC, *clients receiving hospice services*); and

(4) if the selection or assignment is made after the 25th day of the month and before the first full day of the following month, the enrollment begins on the first day of the second month after the selection or assignment.

E. **Member lock-in:** Member enrollment in an MCO runs for a 12-month cycle. During the first 90 days after a member initially selects or is assigned to an MCO, the member shall have the option to choose a different MCO to provide care during the member's remaining period of managed care enrollment.

(1) If the member does not choose a different MCO, the member will continue to receive care from the MCO that provided the member's care in the first 90 days.

(2) If, during the member's first 90 days with an MCO, he chooses a different MCO, the member will have a 90-day open enrollment period with this new MCO.

(3) After exercising his switching rights, and returning to a previously selected MCO, the member shall remain with this MCO until his twelve (12)-month lock-in period expires before being permitted to switch MCOs.

(4) At the conclusion of the 12-

month cycle, the member shall have the same choices offered at the time of initial enrollment. The member shall be notified 60 days prior to the expiration date of the member's lock-in period of the expiration of the lock-in and the deadline by when to choose a new MCO.

(5) If a member loses medicaid eligibility for a period of two months or less, he will be automatically reenrolled with the former MCO. If the member misses the annual disenrollment opportunity during this two-month time, he may request to be assigned to another MCO.

F. **Member switch enrollment:** A member who is required to enroll in managed care may request to be disenrolled from an MCO and switch to another MCO "for cause" at any time. The member or his representative shall make the request either orally or in writing to HSD. HSD shall review the request and furnish a written response to the member and the MCO no later than the first day of the second month following the month in which the member or his representative files the request. If HSD fails to make a disenrollment determination so that the member may be disenrolled during this timeframe, the disenrollment is considered approved. A member who is denied disenrollment shall have access to HSD's fair hearing process. The following criteria shall be cause for disenrollment:

(1) continuity of care issues;

(2) family continuity;

(3) administrative or data entry error in assigning a client to an MCO;

(4) assignment of a member where travel for primary care exceeds community standards (90% of urban residents shall travel no further than 30 miles to see a PCP; 90% of rural residents shall travel no further than 45 miles to see a PCP; and 90% of frontier residents shall travel no further than 60 miles to see a PCP); urban counties are: Bernalillo, Los Alamos, Santa Fe and Dona Ana; frontier counties are: Catron, Harding, DeBaca, Union, Guadalupe, Hidalgo, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, San Miguel and Cibola; rural counties are those which are not listed as urban or frontier;

(5) the member moves out of the MCO service area;

(6) the MCO does not, because of moral or religious objections, cover the service the member seeks;

(7) the member needs related services to be performed at the same time, not all related services can be provided by the PCP, and another provider determines that receiving the services separately would subject the member to unnecessary risk; and

(8) other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs.

G. **Exemption:** HSD shall grant exemptions to mandatory enrollment on a case-by-case basis. A client or the client's representative, parent or legal guardian shall request exemption in writing to HSD, describing the special circumstances that warrant an exemption. Alternatively, HSD may initiate an exemption on a case-by-case basis. Requests for exemption shall be evaluated by HSD clinical staff and forwarded to the medical assistance division medical director or designee for final determination. Clients shall be notified of the disposition of exemption requests. A client requesting an exemption, who is not enrolled in managed care at the time of the exemption request, shall remain exempt until a final determination is made. A client already in managed care at the time of the exemption request shall remain in managed care until a final determination is made. HSD shall review the request and furnish a written response to the client no later than the first day of the second month following the month in which the client files the request. If HSD fails to make a determination so that the client may become exempt within this timeframe, the exemption is considered approved. A client who is denied exemption shall have access to HSD's fair hearing process.

H. **Disenrollment, MCO initiated:** The MCO may request that a particular member be disenrolled. Member disenrollment from an MCO will be considered in rare circumstances. Disenrollment requests must be made in writing to HSD. The request and supporting documentation must meet HSD requirements. The MCO shall not request disenrollment because of an adverse change in the member's health status or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his special needs (except when his continued enrollment with the MCO seriously impairs the MCO's ability to furnish services to either this particular member or other members). The MCO shall notify the member in writing of the disenrollment request at the same time the request is submitted to HSD. The MCO shall submit a copy of the member's notification letter to HSD. If the disenrollment is granted, the MCO retains responsibility for the member's care until the member is enrolled with another MCO or exempted from Salud!. The MCO must assist with transition of care.

I. **Conditions under which an MCO requests member disenrollment:** Conditions under which an MCO may request disenrollment are:

(1) the MCO demonstrates a good faith effort has been made to accommodate the member and address the member's problems, but those efforts have been unsuccessful;

(2) the conduct of the member does not allow the MCO to safely or prudently provide medical or behavioral health care subject to the terms of the contract;

(3) the MCO has offered to the member in writing the opportunity to use the grievance procedures; and

(4) the MCO has received threats or attempts of intimidation from the member to the MCO's providers or MCO staff.

J. **Re-enrollment limitations:** If a request for disenrollment is approved, the member shall not be re-enrolled with the requesting MCO for a period of time to be determined by HSD. The member and the requesting MCO shall be notified by HSD of the period of disenrollment. If a member has been disenrolled by all contracted MCOs, HSD shall evaluate the member for medical management.

K. **Date of disenrollment:** MCO enrollment upon approval, shall terminate at the end of a calendar month.

[8.305.5.9 NMAC - Rp 8.305.5.9 NMAC, 7-1-04]

8.305.5.10 ENROLLMENT ROSTERS: The MCO shall receive a monthly roster with the aggregate number of members, member names, member addresses, member social security numbers, member rate cells and member capitation amounts.

[8.305.5.10 NMAC - Rp 8.305.5.10 NMAC, 7-1-04]

8.305.5.11 MEMBER IDENTIFICATION CARD: The MCO shall issue a member identification card within 30 days of enrollment to each member. The card shall be substantially the same as the card issued to commercial enrollees. The card shall not contain information that identifies the member as a medicaid recipient, other than designations commonly used by MCOs to identify for providers the members' benefits, such as group or plan numbers.

[8.305.5.11 NMAC - Rp 8.305.5.14 NMAC, 7-1-04]

8.305.5.12 MASS TRANSFER PROCESS: The mass transfer process is initiated when HSD determines that the transfer of MCO members from one MCO to another is appropriate.

A. **Triggering mass transfer process:** The mass transfer process may be triggered by two situations:

(1) a maintenance change, such as

changes in MCO identification number or MCO name; and

(2) a significant change in MCO contracting status, including but not limited to, loss of licensure, substandard care, fiscal insolvency or significant loss in network providers.

B. **Effective date of mass transfer:** The change in enrollment initiated by the mass transfer begins with the first day of the month following the identification of the need to transfer MCO members.

C. **Member selection period:** Following a mass transfer, MCO members are given an opportunity to select a different MCO.

D. **Mass transfer based on maintenance:** The mass transfer maintenance function may be triggered when the medicaid or managed care status change of the MCO is transparent to the member. For instance, a change in the MCO's medicaid identification number is a system change that requires a mass transfer but is not relevant to the member and service continues with the MCO. Upon initiation of the maintenance function by HSD, members are automatically transferred to the old MCO with a new identification number or name.

E. **Mass transfer based on significant change in contracting status:** The mass transfer function is triggered when the MCO's contract status changes and the change may be significant to the MCO member. Upon initiation of the mass transfer function by HSD, MCO members are transferred to the "transfer to" MCO and notice is sent to members informing them of the transfer and their opportunity to select a different MCO.

[8.305.5.12 NMAC - Rp 8.305.5.15 NMAC, 7-1-04]

8.305.5.13 MEDICAID MANAGED CARE MARKETING GUIDELINES: When marketing to medicaid clients, MCOs must follow the medicaid managed care marketing guidelines.

A. **Minimum marketing and outreach requirements:** Marketing is defined as the act or process of promoting a business or commodity**.** The marketing and outreach material must meet the following minimum requirements:

(1) marketing and outreach materials must meet requirements for all communication with medicaid members, as delineated in the quality standards (8.305.8.15 NMAC, *patient bill of rights*) and incorporated into the managed care contract;

(2) all marketing or outreach materials produced by the MCO under the medicaid managed care contract must state that such services are funded in part under contract with the state of New Mexico;

(3) marketing and outreach information provided to members shall be accurate, not misleading, and non-threatening;

(4) if there is a prevalent population of 5% in the MCO membership that has limited English proficiency, as identified by the MCO or HSD, marketing materials must be available in the language of the prevalent population; and

(5) other requirements specified by the state.

B. **Scope of marketing guidelines:** Marketing materials are defined as brochures and leaflets, newspaper, magazine, radio, television, billboard, MCO yellow page advertisement, web site and presentation materials used by an MCO, and MCO representative or MCO sub-contractor to attract or retain medicaid enrollment. HSD may request, review and approve or disapprove any communication to any medicaid client. MCOs are not restricted by HSD in their general communications to the public. HSD shall approve advertisements mailed to, distributed to, or aimed at medicaid clients and marketing material that mentions medicaid, medical assistance, Title XIX or Salud!. The MCO shall notify HSD of significant format changes to advertisements. Examples of medicaid-specific materials would be those that:

(1) are in any way targeted to medicaid populations, such as billboards or bus posters disproportionately located in low-income neighborhoods;

(2) mention the MCO's medicaid product name; or

(3) contain language or information designed to attract medicaid enrollment.

C. **Advertising and marketing material:** Medicaid-specific advertising and marketing materials, including materials disseminated by a sub-contractor and information disseminated via the Internet require HSD approval. In reviewing this information, HSD shall apply a variety of criteria.

(1) **Accuracy:** The content of the material must be accurate. Information deemed inaccurate shall be disallowed.

(2) **Misleading references to MCO strengths:** Misleading information shall not be allowed even if it is accurate. For example, an MCO may seek to advertise that its health care services are free to medicaid members. HSD would not allow the language because it could be construed by clients as being a particular advantage of the MCO. In other words, they might believe they would have to pay for medicaid health services if they chose another MCO or remained in fee-for-service.

(3) **Threatening messages:** An MCO shall not imply that another managed care program is endangering clients' health status, personal dignity or the opportunity to succeed in various aspects of their lives. An MCO may differentiate itself by promoting its legitimate strengths and positive attributes, but not by creating threatening implications about the mandatory assignment process or other aspects of the program.

D. **Marketing and outreach activities not permitted:** The following marketing and outreach activities are not permitted regardless of the method of communication (oral, written or other means of communication) or whether the activity is performed by the MCO directly, its network providers, its subcontractors or any other party affiliated with the MCO. HSD shall prohibit additional marketing activities at its discretion.

(1) asserting or implying that a member will lose medicaid benefits if he does not enroll with the MCO or creating other scenarios that do not accurately depict the consequences of choosing a different MCO;

(2) designing a marketing or outreach plan which discourages or encourages MCO selection based on health status or risk;

(3) initiating an enrollment request on behalf of a medicaid client;

(4) making inaccurate, misleading or exaggerated statements designed to recruit a potential member;

(5) asserting or implying that the MCO offers unique covered services where another MCO provides the same or similar services;

(6) the use of more than nominal gifts such as diapers, toasters, infant formula or other incentives to entice medicaid clients to join a specific health plan;

(7) telemarketing or face-to-face marketing with potential members;

(8) conducting any other marketing activity prohibited by HSD;

(9) explicit direct marketing to members enrolled with other MCOs unless the member requests the information;

(10) distributing any marketing materials without first obtaining HSD approval;

(11) seeking to influence enrollment in conjunction with the sale or offering of any private insurance;

(12) engaging in door-to-door, telephone or other cold call marketing activities, directly or indirectly; and

(13) other requirements specified by HSD.

E. **Marketing in current care sites:** Promotional materials may be made available to members and potential MCO enrollees in care delivery sites, including patient waiting areas, if HSD has prior approved the content. Face-to-face

meetings at care delivery sites for the purpose of marketing to potential MCO enrollees by MCO staff shall not be permitted.

F. **Provider communications with medicaid clients about MCO options:** HSD marketing restrictions shall apply to MCO subcontractors and providers as well as to the MCO. MCOs are required to notify participating providers of the HSD marketing restrictions, including providing a copy of these regulations. HSD shall not review yellow page ads of individual providers, unless specifically requested to do so.

G. **Client-initiated meetings with MCO staff prior to enrollment:** Face-to-face meetings requested by clients are permitted. These meetings may occur at a mutually agreed upon site. All verbal interaction with the client must be in compliance with the guidelines identified in these regulations.

H. **Mailings by the MCO:** MCO mailings shall be permitted in response to client oral or written requests for information. The content of marketing or promotional mailings shall be prior approved by HSD. MCOs may, with HSD approval, provide potential members with information regarding the MCO benefit package. MCOs shall not send gifts however nominal in value, in these mailings. MCOs may send solicited and unsolicited mailings to members and potential members. Unsolicited mailings are defined as: newsletters; notification of outreach events and member services meetings; educational materials and literature related to the MCO preventive medicine initiatives, (such as, diabetes screening, drug and alcohol awareness, and mammograms). HSD shall approve the content of mailings except health education materials. The target audience of the mailings shall be prior approved by HSD.

I. **Group meetings:** The MCO may hold public meetings. HSD shall be furnished with notice of the meetings and shall prior approve the marketing material to be presented at the meeting. HSD shall approve the methodology used by the MCO to solicit attendance for the public meetings. HSD may attend the meeting.

J. **Light refreshments for clients at meetings:** The MCO may offer light refreshments at approved group meetings. The availability of food and beverages shall not be mentioned in advertisements for the meetings. *Alcoholic beverages shall not be offered at meetings.*

K. **Gifts, cash incentives or rebates to clients:** MCOs and their providers, with HSD approval, may disseminate marketing materials, including nominal gifts such as pens, key chains and magnets to potential members.

L. **Gifts to members at health milestones unrelated to enrollment:** Members may be given "rewards" for accessing care, such as a baby T-shirt when a woman completes a targeted series of prenatal visits. Items that reinforce a member's healthy behavior, (car seats, infant formula, magnets and telephone labels) that advertise the member services hotline and the PCP office telephone number for members are examples of "rewards". HSD shall approve gifts with a retail value of over $25.00. Health education videos may be provided. HSD encourages MCOs to include reward items in information sent to new MCO members.

M. **Marketing time frames:** The MCO may initiate marketing and outreach activities at any time.

[8.305.5.13 NMAC - Rp 8.305.5.16 NMAC, 7-1-04]

HISTORY OF 8.305.5 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:

8 NMAC 4.MAD.606.4, Managed Care Policies, Enrollment In Managed Care, 6-19-97.

History of Repealed Material:

8 NMAC 4.MAD.606.4, Managed Care Policies, Enrollment In Managed Care - Repealed, 7-1-01.

8.305.5 NMAC, Medicaid Managed Care, Enrollment in Managed Care - Repealed, 7-1-04.

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 7 BENEFIT PACKAGE

8.305.7.1 ISSUING AGENCY: Human Services Department

[8.305.7.1 NMAC - Rp 8.305.7.1 NMAC, 7-1-04]

8.305.7.2 SCOPE: This rule applies to the general public.

[8.305.7.2 NMAC - Rp 8.305.7.2 NMAC, 7-1-04]

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

[8.305.7.3 NMAC - Rp 8.305.7.3 NMAC, 7-1-04]

8.305.7.4 DURATION: Permanent

[8.305.7.4 NMAC - Rp 8.305.7.4 NMAC, 7-1-04]

8.305.7.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.

[8.305.7.5 NMAC - Rp 8.305.7.5 NMAC, 7-1-04]

8.305.7.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid managed care program.

[8.305.7.6 NMAC - Rp 8.305.7.6 NMAC, 7-1-04]

8.305.7.7 DEFINITIONS: See 8.305.1.7 NMAC.

[8.305.7.7 NMAC - Rp 8.305.7.7 NMAC, 7-1-04]

8.305.7.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.

[8.305.7.8 NMAC - Rp 8.305.7.8 NMAC, 7-1-04]

8.305.7.9 BENEFIT PACKAGE: This part defines the medicaid benefit package for which the MCO will be paid fixed per-member per-month payment rates. The MCO shall cover these services. The MCO shall not delete benefits from the medicaid-defined benefit package. An MCO is encouraged to provide an enhanced benefit package, which could include health-related educational, preventive, outreach and enhanced physical and behavioral health services. The MCO may utilize providers licensed in accordance with state and federal requirements to deliver services.

[8.305.7.9 NMAC - Rp 8.305.7.9 NMAC, 7-1-04]

8.305.7.10 MEDICAL ASSISTANCE DIVISION PROGRAM POLICY MANUAL: A detailed explanation of the services covered by medicaid, limitations and exclusions to covered services and services that are not covered by medicaid is found in the medical assistance division program manual. The manual is the official source of information on covered and non-covered services. MCOs shall determine their own utilization management (UM) protocols which are based on reasonable medical evidence, and are not bound by those found in the medicaid program manu-

al. HSD may review the MCO's UM protocols.
[8.305.7.10 NMAC - Rp 8.305.7.10 NMAC, 7-1-04]

8.305.7.11 SERVICES INCLUDED IN THE SALUD! BENEFIT PACKAGE:

A. **Inpatient hospital services:** The benefit package includes hospital inpatient acute care, procedures and services for clients, as detailed in 8.311.2 NMAC, *Hospital Services*. The MCO shall comply with the maternity length of stay in the Health Insurance Portability and Accountability Act of 1996. Coverage for a hospital stay following a normal, vaginal delivery may not be limited to less than 48 hours for both the mother and the newborn child. Health coverage for a hospital stay in connection with childbirth following a caesarian section may not be limited to less than 96 hours for mother and newborn child.

B. **Transplant services:** The benefit package includes transplantation services not considered experimental or investigational**.** The following transplants are covered in the benefit package as long as the indications are not considered experimental or investigational: heart transplants, lung transplants, heart-lung transplants, liver transplants, kidney transplants, autologous bone marrow transplants, allogeneic bone marrow transplants and corneal transplants, as detailed in 8.325.5 NMAC, *Transplant Services*. Also see 8.325.6 NMAC, *Experimental or Investigational Procedures, Technologies or Non-Drug Therapies* for guidance on determining if transplants are experimental or investigational.

C. **Hospital outpatient service:** The benefit package includes hospital outpatient services for preventive, diagnostic, therapeutic, rehabilitative or palliative medical or behavioral health services as detailed in 8.311.2 NMAC, *Outpatient Covered Services.*

D. **Case management services:** The benefit package includes case management services necessary to meet an identified service need as detailed in 8.326.2 NMAC through 8.326.6 NMAC and 8.320.5 NMAC.

E. **Specific case management programs:** The following are specific case management programs available to medicaid clients within the MCO, which meet the requirements specified in policy manual parts:

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

(2) **Case management services for pregnant women and their infants:** Case management services provided to pregnant women up to 60 days following the end of the month of the delivery, as detailed in 8.326.3 NMAC, *Case Management Services for Pregnant Women and Their Infants*;

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

(4) **Case management services for traumatically brain injured adults:** Case management services provided to adults who are 21 years of age or older who are traumatically brain injured, as detailed in 8.326.5 NMAC, *Case Managed Services for Traumatically Brain Injured Adults*;

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

(6) **Case management services for the medically at risk:** Case management services for individuals who are under 21 who are medically at risk for physical or behavioral health conditions, as detailed in 8.320.5 NMAC, *EPSDT Case Management*. The benefit package does not include case management provided to developmentally disabled children ages 0-3 who are receiving early intervention services, or case management services provided by the children, youth and families department and defined as protective services case management or juvenile probation and parole officer case management. "Medically at risk" is defined as those individuals who have a diagnosed physical or behavioral health condition which has a high probability of impairing their cognitive, emotional, neurological, social, behavioral or physical development.

F. **Emergency services:** The benefit package includes inpatient and outpatient services meeting the definition of emergency services. Services must be available 24 hours per day and 7 days per week. Services meeting the definition of emergency services must be provided without regard to prior authorization or the provider's contractual relationship with the MCO. If the services are needed immediately and the time necessary to transport the member to a network provider would mean risk of permanent damage to the member's health, emergency services must be available through a facility or provider participating in the MCO network or from a facility or provider not participating in the MCO network. Either provider type must be paid for the provision of services on a timely basis. Emergency services include services needed to evaluate and stabilize an emergency medical or behavioral condition. Post stabilization care services means covered services, related to an emergency medical or behavioral condition, that are provided after a member is stabilized in order to maintain this stabilized condition. This coverage may include improving or resolving the member's condition if either the MCO has authorized post-stabilization services in the facility in question, or there has been no authorization; and

(1) the hospital was unable to contact the MCO; or

(2) the hospital contacted the MCO but did not get instructions within an hour of the request.

G. **Physical health services:** The benefit package includes primary (including those provided in school-based settings) and specialty physical health services provided by a licensed practitioner performed within the scope of practice, as defined by state law and detailed in 8.310.2 NMAC, *Medical Services Providers*; 8.310.9 NMAC, *Midwife Services*; 8.310.9 NMAC, *Podiatry Services*; 8.310.3 NMAC, *Rural Health Clinic Services*; and 8.310.4 NMAC, *Federally Qualified Health Center Services*.

H. **Laboratory services:** The benefit package includes laboratory services provided according to the applicable provisions of Clinical Laboratory Improvement Act (CLIA), as detailed in 8.324.2 NMAC, *Laboratory Services*.

I. **Diagnostic imaging and therapeutic radiology services:** The benefit package includes medically necessary diagnostic imaging and radiology services, as detailed in 8.324.3 NMAC, *Diagnostic Imaging and Therapeutic Radiology Services*.

J. **Anesthesia services:** The benefit package includes anesthesia and monitoring services necessary for the performance of surgical or diagnostic procedures, as detailed in 8.310.5 NMAC, *Anesthesia Services*.

K. **Vision services:** The benefit package includes vision services, as detailed in 8.310.6 NMAC, *Vision Care Services*.

L. **Audiology services:** The benefit package includes audiology services, as detailed in 8.324.6 NMAC, *Hearing Aids and Related Evaluation*.

M. **Dental services:** The benefit package includes dental services, as

detailed in 8.310.7 NMAC, *Dental Services*.

N. **Dialysis services:** The benefit package includes medically necessary dialysis services, as detailed in 8.325.2 NMAC, *Dialysis Services*. Dialysis providers must assist members in applying for and pursuing final medicare eligibility determination.

O. **Pharmacy services:** The benefit package includes all pharmacy and related services, as detailed in 8.324.4 NMAC, *Pharmacy Services*. The MCO shall maintain written policies and procedures governing its drug utilization review (DUR) program in compliance with all applicable federal medicaid laws.

P. **Durable medical equipment and medical supplies:** The benefit package includes the purchase, delivery, maintenance and repair of equipment, oxygen and oxygen administration equipment, nutritional products, disposable diapers, augmentative alternative communication devices and disposable supplies essential for the use of the equipment, as detailed in 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies*.

Q. **EPSDT services:** The benefit package includes the delivery of the federally mandated early and periodic screening, diagnostic and treatment (EPSDT) services provided by a PCP and physical or behavioral health specialist, as detailed in 8.320.2 NMAC, *EPSDT Services*.

R. **Tot-to-teen health checks:** The MCO shall adhere to the periodicity schedule and ensure that eligible members receive EPSDT screens (tot-to-teen health checks). The services include the following with respect to treatment follow-up:

(1) education of and outreach to members regarding the importance of the health checks;

(2) development of a proactive approach to ensure that the members receive the services;

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

(4) development of a systematic communication process with MCO network providers regarding screens and treatment coordination;

(5) processes to document, measure and assure compliance with the periodicity schedule; and

(6) development of a proactive process to insure the appropriate follow-up evaluation, referral and treatment, including early intervention for mental or behavioral health conditions, vision and hearing screening, dental examinations and current immunizations.

S. **EPSDT private duty nursing:** The benefit package includes private duty nursing for the EPSDT population, as detailed in 8.323.4 NMAC, *EPSDT Private Duty Nursing Services*. The services must either be delivered in the member's home or the school setting.

T. **EPSDT personal care:** The benefit package includes personal care services for the EPSDT population, as detailed in 8.323.2 NMAC, *EPSDT Personal Care Services*.

U. **Services provided in schools:** The benefit package includes services provided in schools, excluding those specified in the individual education plan (IEP) or the individualized family service plan (IFSP), as detailed in 8.320.6 NMAC, *School-Based Services for Recipients under 21 Years Of Age*.

V. **Nutritional services:** The benefit package includes nutritional services furnished to pregnant women and children as detailed in 8.324.9 NMAC, *Nutrition Services*.

W. **Home health services:** The benefit package includes home health services, as detailed in 8.325.9 NMAC, *Home Health Services*. The MCO is required to coordinate home health and the home and community-based waiver programs if a member is eligible for both home health and waiver services.

X. **Hospice services:** The benefit package includes hospice services, as detailed in 8.325.4 NMAC, *Hospice Care Services*.

Y. **Ambulatory surgical services:** The benefit package includes surgical services rendered in an ambulatory surgical center setting, as detailed in 8.324.10 NMAC, *Ambulatory Surgical Center Services*.

Z. **Rehabilitation services:** The benefit package includes inpatient and outpatient hospital and outpatient physical, occupational and speech therapy services, as detailed in 8.325.8 NMAC, *Rehabilitation Services Providers* and licensed speech and language pathology services furnished under the EPSDT program as detailed in 8.323.5 NMAC, *Licensed Speech And Language Pathologists*. The MCO is required to coordinate rehabilitation and the home health and the home and community-based waiver programs if a member is eligible for rehabilitation, home health and waiver services.

AA. **Reproductive health services:** The benefit package includes reproductive health services, as detailed in 8.325.3 NMAC, *Reproductive Health Services*. The MCO will provide female members with direct access to women's health specialists within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.

(1) The MCO shall provide medicaid members with sufficient information to allow them to make informed choices including the following:

(a) types of family planning services available;

(b) a member's right to access these services in a timely and confidential manner; and

(c) freedom to choose a qualified family planning provider who participates in the MCO network or from a provider who does not participate in the MCO network.

(2) If members choose to receive family planning services from an out-of-network provider, they shall be encouraged to exchange medical information between the PCP and the out-of-network provider for better coordination of care.

BB. **Pregnancy termination procedures:** The benefit package includes services for the termination of pregnancy and pre- or post-decision counseling or psychological services, as detailed in 8.325.7 NMAC, *Pregnancy Termination Procedures*.

CC. **Emergency and non-emergency transportation services:** The benefit package includes transportation service such as ground ambulance, air ambulance, taxicab and handivan, commercial bus, commercial air, meal and lodging services as indicated for medically necessary physical and behavioral health services, as detailed in 8.324.7 NMAC, *Transportation Services*. Non-emergency transportation is covered only when a member does not have a source of transportation available and when the member does not have access to alternative free sources.

DD. **Prosthetics and orthotics:** The benefit package includes prosthetic and orthotic services as detailed in 8.324.8 NMAC, *Prosthetics and Orthotics*.

[8.305.7.11 NMAC - Rp 8.305.7.11 NMAC, 7-1-04]

8.305.7.12 SERVICES EXCLUDED FROM THE SALUD! BENEFIT PACKAGE: The following services are not included in the Salud! benefit package. Reimbursement for these services shall be made by medicaid fee-for-service. However, the MCO is expected to coordinate these services, when applicable, and ensure continuity of care by overseeing PCP consultations, medical record updates and general coordination. The excluded services include the following:

A. services provided in nursing facilities or hospital swing beds to

clients expected to reside in those facilities on a long-term or permanent basis, as defined in 8.312.2 NMAC, *Nursing Facilities* and 8.311.5 NMAC, *Swing Bed Hospital Services;*

B. services provided in intermediate care facilities for the mentally retarded, as defined in 8.313.2 NMAC, *Intermediate Care Facilities for the Mentally Retarded*;

C. services provided pursuant to the home and community-based services waiver programs, as defined in Chapter 314, *Long Term Care Services - Waivers*;

D. emergency services to undocumented aliens defined in 8.325.10 NMAC, *Emergency Services for Undocumented Aliens*;

E. early intervention therapy and case management services, as detailed in 8.320.4 NMAC, *Special Rehabilitation Services*;

F. case management provided by the children youth and families department defined as child protective services case management and as detailed in 8.320.5 NMAC, *EPSDT Case Management*;

G. case management provided by the children, youth and families department, as detailed in 8.326.7 NMAC, *Adult Protective Services Case Management*;

H. case management provided by the children, youth and families department, as detailed in 8.326.8 NMAC, *Case Management for Children Provided by Juvenile Probation and Parole Officers*;

I. services provided in the schools and specified in the individual education plan (IEP) or individualized family service plan (IFSP), as detailed in 8.320.6 NMAC, *School-Based Services for Recipients under 21 Years of Age*; and

J. experimental or investigational procedures, technologies or therapies, as defined in 8.325.6 NMAC, *Experimental or Investigational Procedures, Technologies or Non-Drug Therapies*. Services that meet the definition of experimental or investigational are not covered under Salud! medicaid or fee-for-service.

[8.305.7.12 NMAC - Rp 8.305.7.12 NMAC, 7-1-04]

8.305.7.13 BEHAVIORAL HEALTH SERVICES INCLUDED IN THE BENEFIT PACKAGE FOR ADULTS AND CHILDREN.

A. **Inpatient hospital services:** The benefit package includes inpatient hospital psychiatric services provided in general hospital units and prospective payment system (PPS)-exempt units in a general hospital as detailed in 8.311.2 NMAC, *Hospital Services*.

B. **Hospital outpatient services:** The benefit package includes outpatient psychiatric and partial hospitalization services provided in PPS-exempt units of general hospitals as detailed in 8.311.4 NMAC, *Outpatient Psychiatric Services and Partial Hospitalization*.

C. **Outpatient health care professional services:** The benefit package includes outpatient health care services, as detailed in 8.310.8 NMAC, *Mental Health Professional Services*.

[8.305.7.13 NMAC - Rp 8.305.7.13 NMAC, 7-1-04]

8.305.7.14 BEHAVIORAL HEALTH SERVICES INCLUDED IN THE SALUD! BENEFIT PACKAGE FOR CHILDREN ONLY: The benefit package includes prevention, screening, diagnostic, ameliorative services and other medically necessary behavioral health care and substance abuse treatment or services for medicaid members under 21 years of age whose need for behavioral health services is identified by a licensed health care provider and/or during an EPSDT screen. All behavioral health care services must be provided in accordance with the current New Mexico Children's Code and the Children's Mental Health and Developmental Disabilities Act, NMSA Section 32A-6-1 to 32A-6-22. The services include the following:

A. **Inpatient hospitalization in free standing psychiatric hospitals:** The benefit package includes inpatient services in free standing psychiatric hospitals as detailed in 8.321.2 NMAC, *Inpatient Psychiatric Care in Freestanding Psychiatric Hospitals*.

B. **Accredited residential treatment center services:** The benefit package includes accredited residential treatment services as detailed in 8.321.3 NMAC, *Accredited Residential Treatment Center Services*.

C. **Nonaccredited residential treatment centers and group homes:** The benefit package includes residential treatment services as detailed in 8.321.4 NMAC, *Non-Accredited Residential Treatment Centers and Group Homes*.

D. **Treatment foster care:** The benefit package includes treatment foster care services as detailed in 8.322.2 NMAC, *Treatment Foster Care*.

E. **Treatment foster care II:** The benefit package includes treatment foster care II, as detailed in 8.322.5 NMAC, *Treatment Foster Care II*.

F. **Outpatient and partial hospitalization services in freestanding psychiatric hospital:** The benefit package includes outpatient and partial hospitalization services provided in freestanding psychiatric hospitals, as detailed in 8.321.5 NMAC, *Outpatient and Partial Hospitalization Services in Freestanding Psychiatric Hospitals*.

G. **Day treatment services:** The benefit package includes day treatment services, as detailed in 8.322.4 NMAC, *Day Treatment Services*.

H. **Behavior management skills development services (BMSDS):** The benefit package includes behavior management services, as detailed in 8.322.3 NMAC, *Behavior Management Skills Development Services*.

I. **School-based services:** The benefit package includes counseling, evaluation and therapy furnished in a school-based setting, but not when specified in the individual education plan (IEP) or the individualized family service plan (IFSP), as detailed in 8.320.6 NMAC, *School-Based Services for Recipients under 21 Years of Age*.

J. **Case management services for the medically-at-risk:** The benefit package includes case management services for individuals who are under 21 who are medically-at-risk for behavioral health conditions, as detailed in 8.320.5 NMAC, *EPSDT Case Management*.

K. **Licensed alcohol and drug abuse counselors:** The benefit package includes alcohol and drug abuse counseling, as detailed in 8.323.3 NMAC, *Licensed Alcohol and Drug Abuse Counselors*.

[8.305.7.14 NMAC - Rp 8.305.7.14 NMAC, 7-1-04]

8.305.7.15 BEHAVIORAL HEALTH SERVICES INCLUDED IN THE BENEFIT PACKAGE FOR ADULTS ONLY: The following services which must be provided in accordance with the New Mexico Mental Health and Developmental Disabilities Code.

A. **Psychosocial rehabilitation:** The benefit package includes psychosocial rehabilitation services as detailed in 8.315.3 NMAC, *Psychosocial Rehabilitation Services*.

B. **Case management services for the chronically mentally ill:** The benefit package includes case management services as detailed in 8.326.4 NMAC, *Case Management Services for the Chronically Mentally Ill.*

[8.305.7.15 NMAC - Rp 8.305.7.15 NMAC, 7-1-04]

8.305.7.16 ENHANCED SERVICES: MCOs are encouraged to offer members a package of enhanced services.

The cost of these services cannot be included when HSD determines the payment rates.

A. **Potential enhanced services:** The following are suggested enhanced services:

(1) anticipatory guidance provided as a part of the normal course of office visits or a health education program;

(2) comprehensive prenatal services including counseling, child birth education, parenting skills and referral to other support services;

(3) targeting the coordination of services necessary to optimize the member's level of health and functionality;

(4) child abuse and neglect prevention programs;

(5) stress control programs;

(6) car seats for infants and children;

(7) culturally-traditional indigenous healers and treatments;

(8) smoking cessation programs;

(9) weight loss programs;

(10) violence prevention and referral for support services;

(11) substance abuse prevention and treatment, beyond the benefit package;

(12) respite care for care givers;

(13) structured HIV education programs;

(14) programs that educate members on how to most efficiently and effectively use the health care system; and

(15) other enhanced services, including behavioral health enhanced services, at the MCO's discretion.

B. **Targeted enhanced services:** Other services may be made available to members based on the MCO's discretion. Eligibility for enhanced services may be based upon a set of assessment criteria to be employed by the MCO.

[8.305.7.16 NMAC - Rp 8.305.7.16 NMAC, 7-1-04]

8.305.7.17 PERSONAL CARE OPTION (PCO) SERVICES: The MCOs shall under the direction of HSD or its designee provide home assessments with service plans and utilization review for PCO services. If necessary, the MCOs shall provide summaries of evidence for HSD fair hearings and participation in the fair hearing process for their own MCO members and for exempt medicaid-eligible members as agreed to in the contracts between HSD and the MCOs.

[8.305.7.17 NMAC - N, 7-1-04]

HISTORY OF 8.305.7 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:

8 NMAC 4.MAD.606.6, Managed Care Policies, Benefit Package, 6-19-97.

History of Repealed Material:

8 NMAC 4.MAD.606.6, Managed Care Policies, Benefit Package - Repealed, 7-1-01.

8.305.7 NMAC, Medicaid Managed Care, Benefit Package - Repealed 7-1-04.

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 9 COORDINATION OF SERVICES

8.305.9.1 ISSUING AGENCY: Human Services Department

[8.305.9.1 NMAC - Rp 8.305.9.1 NMAC, 7-1-04]

8.305.9.2 SCOPE: This rule applies to the general public.

[8.305.9.2 NMAC - Rp 8.305.9.2 NMAC, 7-1-04]

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

[8.305.9.3 NMAC - Rp 8.305.9.3 NMAC, 7-1-04]

8.305.9.4 DURATION: Permanent

[8.305.9.4 NMAC - Rp 8.305.9.4 NMAC, 7-1-04]

8.305.9.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.

[8.305.9.5 NMAC - Rp 8.305.9.5 NMAC, 7-1-04]

8.305.9.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid managed care program.

[8.305.9.6 NMAC - Rp 8.305.9.6 NMAC, 7-1-04]

8.305.9.7 DEFINITIONS: See 8.305.1.7 NMAC.

[8.305.9.7 NMAC - Rp 8.305.9.7 NMAC, 7-1-04]

8.305.9.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.

[8.305.9.8 NMAC - Rp 8.305.9.8 NMAC, 7-1-04]

8.305.9.9 COORDINATION OF SERVICES:

A. The MCO shall develop and implement policies and procedures to ensure access to care coordination for individuals with special health care needs (ISHCN) as defined in 8.305.15.9 NMAC. Care coordination is defined as a service to assist clients with special health care needs, on an as needed basis. It is member-centered, family-focused when appropriate, culturally competent and strength-based. Care coordination can help to ensure that the medical and behavioral health needs of the Salud! population are identified and services are provided and coordinated with all service providers, individual members and family if appropriate. Care coordination operates within the MCO with a dedicated care coordination staff functioning independently but is structurally linked to the other MCO systems, such as quality assurance, member services and grievances. Clinical decisions shall be based on the medically necessary covered services and not fiscal considerations. If both physical and behavioral health conditions exist, the care shall be coordinated between both physical and behavioral health staff, and the responsibility for the care coordination shall be based upon what is in the best interest of the member. The MCO shall use the following primary elements for care coordination:

(1) identify proactively the eligible populations;

(2) identify proactively the needs of the eligible population;

(3) provide a designated person as primarily responsible for coordinating the health services furnished and to serve as the single point of contact for the member;

(4) communicate to the member the care coordinator's name and how to contact him/her;

(5) ensure access to a qualified provider who is responsible for developing and implementing a comprehensive treatment plan as per applicable provider regulations;

(6) ensure the provision of necessary services and actively assist members and providers in obtaining such services;

(7) ensure appropriate coordination between physical and behavioral health services and non-Salud! services;

(8) coordinate with designated case managers and/or medical/behavioral health care service providers;

(9) monitor progress of the mem-

bers to ensure that services are received, assist in resolving identified problems, and prevent duplication of services; and

(10) be responsible for linking individuals to case management when needed if a local case manager/designated provider is not available.

B. For clarification purposes, activities provided through care coordination at the MCO level differ from case management activities provided as part of the six specific case management programs included in the medicaid benefit package. The case management programs are defined in 8.326.2 NMAC through 8.326.6 NMAC and 8.320.5 NMAC.

[8.305.9.9 NMAC - Rp 8.305.9.9 NMAC, 7-1-04]

8.305.9.10 COORDINATION OF PHYSICAL AND BEHAVIORAL HEALTH SERVICES BENEFITS:

A. **Coordination of physical and behavioral health services:** Physical and behavioral health services must be provided through an integrated, clinically coordinated system. Both physical and behavioral health care providers need access to relevant medical records of mutually served members to ensure maximum benefits of services to the member. Confidentiality and HIPAA laws apply during this coordination process.

B. **Coordination mechanisms:** The MCO shall implement policies and procedures designed to maximize the coordination of physical and behavioral health services and address the medical and behavioral health needs of the member.

C. **Referrals for behavioral health services:** The PCP shall identify behavioral health needs of members, and encourage and assist members in accessing behavioral health services.

D. **Referrals for physical health services:** The behavioral health provider shall encourage and assist the member in accessing needed physical health services.

E. **Referral policies and procedures:** The MCO shall develop and implement policies and procedures that encourage PCPs to refer members to behavioral health services in an appropriate and timely manner with the member's documented permission. A written report of the outcome of any referral containing sufficient information to coordinate the member's care shall be forwarded to the PCP by the behavioral health provider within 7 calendar days after screening and evaluation.

F. **Indicators for PCP referral for behavioral health services:** The following are common indicators for referral to behavioral health services by a PCP:

(1) suicidal/homicidal ideation or behavior;

(2) at-risk of hospitalization due to a behavioral health condition;

(3) children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital or residential treatment facility;

(4) trauma victims including possible abused or neglected members;

(5) serious threat of physical or sexual abuse or risk to life or health due to impaired mental status and judgment, mental retardation, or other developmental disabilities;

(6) request by member, parent and/or legal guardian of a minor for behavior health services;

(7) clinical status which suggests the need for behavioral health services;

(8) identified psychosocial stressors and precipitants;

(9) treatment compliance complicated by behavioral characteristics;

(10) behavioral and psychiatric factors influencing medical condition;

(11) victims or perpetrators of abuse and neglect;

(12) non-medical management of substance abuse;

(13) follow-up to medical detoxification;

(14) an initial PCP contact or routine physical examination indicates a substance abuse problem;

(15) a prenatal visit indicates substance abuse problems;

(16) positive response to questions indicates substance abuse, observation of clinical indicators or laboratory values that indicate substance abuse;

(17) a pattern of inappropriate use of medical, surgical, trauma or emergency room services that could be related to substance abuse or other behavioral health conditions; and

(18) the persistence of serious functional impairment.

G. **Referrals for medical consultation and treatment:** The MCO shall educate and assist behavioral health providers to make appropriate referrals for physical health consultation and treatment.

H. **Independent access:** The MCOs shall develop and implement policies and procedures that allow member access to behavioral health services directly and without referral from the PCP. These policies and procedures shall require timely access to behavioral health services.

I. **Behavioral health plan of care:** A behavioral health provider or the PCP will take responsibility for developing and implementing the member's behavioral health plan of care, in coordination with the member, parent and/or legal guardian and other providers when clinically indicated. With the member's documented permission, multiple behavioral health providers will coordinate their treatment plans and progress information to provide optimum care for the member. Care coordinators and case managers will be responsible for monitoring the coordination of the plan of care and information sharing for members receiving behavioral health care from multiple providers.

J. **On-going reporting:**

(1) With the member's documented permission, the behavioral health provider shall keep the member's PCP informed of the following:

(a) drug therapy;

(b) laboratory and radiology results;

(c) sentinel events such as hospitalization, emergencies, and incarceration;

(d) discharge from a psychiatric hospital or from behavioral health services; and

(e) transitions in level of care.

(2) With the member's documented permission, the PCP shall keep the behavioral health provider informed of the following:

(a) drug therapy;

(b) laboratory and radiology results;

(c) medical consultations; and

(d) sentinel events such as hospitalization and emergencies.

K. **Psychiatric consultation:** The PCP and other behavioral health providers are encouraged to obtain consultations and assistance with psychopharmacotherapy and diagnostic evaluations from a psychiatrist or other behavioral health specialist with prescribing authority when clinically appropriate.

[8.305.9.10 NMAC - Rp 8.305.9.10 NMAC, 7-1-04]

8.305.9.11 COORDINATION WITH WAIVER PROGRAMS: There are four home and community-based medicaid waiver programs. These are the developmental disabilities waiver, the disabled and elderly waiver, the medically fragile waiver and the HIV-AIDS waiver. Members participating in these waiver programs may also participate in managed care and are eligible for the MCO benefit package. In addition, the member shall receive waiver services, which are excluded from managed care. Case management is an integral part of each waiver. The waiver program is responsible for case management for waiver recipients. The MCO shall assist with care coordination. The MCO shall coordinate care with the member's waiver case manager to ensure that case information is shared, following HIPAA guidelines,

and that necessary services are provided and are not duplicated. HSD shall monitor utilization of services by waiver recipients to ensure that the MCO provides to members who are waiver participants all benefits included in the Salud! benefit package.
[8.305.9.11 NMAC - Rp 8.305.9.11 NMAC, 7-1-04]

8.305.9.12 COORDINATION OF SERVICES WITH CHILDREN, YOUTH AND FAMILIES DEPARTMENT: The MCO shall have policies and procedures governing coordination of services with the CYFD protective services division (PSD) and juvenile justice division (JJD). If the member is receiving case management services through CYFD, the primary responsibility for case management remains with CYFD and the MCO shall assist with care coordination. Care coordination shall ensure that members receive medically necessary services, including behavioral health services, regardless of the member's custody status. If child protective services (CPS), juvenile justice division (JJD) or adult protective services (APS) has an open case on a member, the CYFD social worker assigned to the case shall be involved in the assessment and treatment plan, including decisions regarding the provision of services for the member. The MCO shall designate a single contact point within the MCO for these care coordination purposes.

A. **Children's Code compliance:** These policies and procedures shall comply with the current New Mexico Children's Code.

B. **Adult Protective Services Act compliance:** The MCO's policies and procedures shall comply with New Mexico Statutes, Chapter 27, Section 7 (27-7-14 through 27-7-31), the "Adult Protective Services Act."
[8.305.9.12 NMAC - Rp 8.305.9.12 NMAC, 7-1-04]

8.305.9.13 COORDINATION OF SERVICES WITH SCHOOLS: The MCO shall implement policies and procedures regarding coordination with the public schools for members receiving medicaid services excluded from managed care as specified by an individual education plan (IEP) or individualized family service plan (IFSP). If the member receives case management through the IEP or IFSP, the primary responsibility for case management remains with the school and the MCO shall assist with care coordination. Coordination between the schools and the MCO shall ensure that members receive medically necessary services which complement the IEP or IFSP services and promote the highest level of function for the child. The MCO shall be responsible for having policies and procedures for coordination of services for children returning to school after extended absences, which may be due to inpatient or residential treatment placement.
[8.305.9.13 NMAC - Rp 8.305.9.13 NMAC, 7-1-04]

HISTORY OF 8.305.9 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:
8 NMAC 4.MAD.606.8, Managed Care Policies, Coordination of Services, 6-19-97.

History of Repealed Material:
8 NMAC 4.MAD.606.8, Managed Care Policies, Coordination of Services - Repealed, 7-1-01.
8.305.9 NMAC, Medicaid Managed Care, Coordination of Services - Repealed 7-1-04.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 12 MCO MEMBER GRIEVANCE SYSTEM

8.305.12.1 ISSUING AGENCY: Human Services Department
[8.305.12.1 NMAC - Rp 8.305.12.1 NMAC, 7-1-04]

8.305.12.2 SCOPE: This rule applies to the general public.
[8.305.12.2 NMAC - Rp 8.305.12.2 NMAC, 7-1-04]

8.305.12.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.305.12.3 NMAC - Rp 8.305.12.3 NMAC, 7-1-04]

8.305.12.4 DURATION: Permanent
[8.305.12.4 NMAC - Rp 8.305.12.4 NMAC, 7-1-04]

8.305.12.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.305.12.5 NMAC - Rp 8.305.12.5 NMAC, 7-1-04]

8.305.12.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid managed care program.
[8.305.12.6 NMAC - Rp 8.305.12.6 NMAC, 7-1-04]

8.305.12.7 DEFINITIONS: See 8.305.1.7 NMAC.
[8.305.12.7 NMAC - Rp 8.305.12.7 NMAC, 7-1-04]

8.305.12.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.305.12.8 NMAC - Rp 8.305.12.8 NMAC, 7-1-04]

8.305.12.9 GRIEVANCE SYSTEM:

A. The MCO shall have a grievance system in place for members that includes a grievance process related to dissatisfaction, and an appeals process related to an MCO action, including the opportunity to request an HSD fair hearing.

B. A grievance is a member's expression of dissatisfaction about any matter or aspect of the MCO or its operation other than an MCO action.

C. An appeal is a request for review by the MCO of an MCO action. An action is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure to provide services in a timely manner. An untimely service authorization constitutes a denial and is thus considered an action.

D. The member, legal guardian of the member for minors or incapacitated adults, or a representative of the member as designated in writing to the MCO, has the right to file a grievance or an appeal of an MCO action on behalf of the member. A provider acting on behalf of the member and with the member's written consent may file a grievance and/or an appeal of an MCO action.

E. In addition to the MCO grievance and appeal process described above, a member, legal guardian of the member for a minor or an incapacitated adult, or the representative of the member has the right to request a fair hearing on behalf of the member with HSD directly as described in 8.352.2. NMAC, *Fair Hearings,* if an MCO decision results in termination, modification, suspension, reduction, or denial of services to the member or if the member believes the MCO has taken an action erroneously. A fair hearing may

be requested prior to, concurrent with, subsequent to or in lieu of a grievance or appeal to an MCO.
[8.305.12.9 NMAC - Rp 8.305.12.9 NMAC, 7-1-04]

8.305.12.10 GENERAL REQUIREMENTS FOR GRIEVANCE AND APPEALS:

A. The MCO shall implement written policies and procedures describing how the member may register a grievance or an appeal with the MCO or register a request for a fair hearing with HSD. The policy should include a description of how the MCO resolves the grievance or appeal.

B. The MCO shall provide to all service providers in the MCO's network a written description of the MCO's grievance and appeal process and how the provider can submit a grievance and/or appeal.

C. The MCO shall have available reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

D. The MCO shall name a specific individual(s) designated as the MCO's medicaid member grievance coordinator with the authority to administer the policies and procedures for resolution of a grievance and/or an appeal, to review patterns/trends in grievances and/or appeals, and to initiate corrective action.

E. The MCO shall ensure that the individuals who make decisions on grievances and/or appeals are not involved in any previous level of review or decision-making. The MCO shall also ensure that health care professionals with appropriate clinical expertise will make decisions for the following:

(1) an appeal of an MCO denial that is based on lack of medical necessity;

(2) an MCO denial that is upheld in an expedited resolution;

(3) a grievance or appeal that involves clinical issues.

F. Upon enrollment, the MCO shall provide members, at no cost, with a member information sheet or handbook that provides information on how they and/or their representative(s) can file a grievance and/or an appeal, and the resolution process. The member information shall also advise members of their right to file a request for an administrative hearing with the HSD hearings bureau, upon notification of an MCO action, or concurrent with or following an appeal of the MCO action. The information shall meet the standards for communication specified in MAD policy 8.305.8.15.(13).

G. The MCO must ensure that punitive or retaliatory action is not taken against a member or a provider that files a grievance and/or an appeal, or a provider that supports a member's grievance and/or appeal.
[8.305.12.10 NMAC - Rp 8.305.12.10 & 11 NMAC, 7-1-04]

8.305.12.11 GRIEVANCE: A grievance is a member's expression of dissatisfaction about any matter or aspect of the MCO or its operation other than an MCO action.

A. A member may file a grievance either orally or in writing with the MCO within 90 calendar days of the date the dissatisfaction occurred. The legal guardian of the member for minors or incapacitated adults, a representative of the member as designated in writing to the MCO, and a provider acting on behalf of the member and with the member's written consent, have the right to file a grievance on behalf of the member.

B. Within five (5) working days of receipt of the grievance, the MCO shall provide the grievant with written notice that the grievance has been received and the expected date of its resolution.

C. The investigation and final MCO resolution process for grievances shall be completed within thirty (30) calendar days of the date the grievance is received by the MCO and shall include a resolution letter to the grievant.

D. The MCO may request an extension from HSD of up to fourteen (14) calendar days if the member requests the extension, or the MCO demonstrates to HSD that there is need for additional information, and the extension is in the member's interest. For any extension not requested by the member, the MCO shall give the member written notice of the reason for the extension within two (2) working days of the decision to extend the timeframe.

E. Upon resolution of the grievance, the MCO shall mail a resolution letter to the member. The resolution letter must include, but not be limited to, the following:

(1) all information considered in investigating the grievance;

(2) findings and conclusions based on the investigation; and

(3) the disposition of the grievance.
[8.305.12.11 NMAC - Rp 8.305.12.9 NMAC, 7-1-04]

8.305.12.12 APPEALS: An appeal is a request for review by the MCO of an MCO action.

A. Action is defined as:

(1) the denial or limited authorization of a requested service, including the type or level of service;

(2) the reduction, suspension, or termination of a previously authorized service;

(3) the denial, in whole or in part, of payment for a service;

(4) the failure of the MCO to provide services in a timely manner, as defined by HSD; or

(5) the failure of the MCO to complete the authorization request in a timely manner as defined in 42 CFR Section 438.408.

B. **Notice of MCO action:** The MCO shall mail a notice of action to the member and/or provider within 10 days of the date of an action except for denial of claims which may result in client financial liability which requires immediate notification. The notice must contain but not be limited to the following:

(1) the action the MCO has taken or intends to take;

(2) the reasons for the action;

(3) the member's or the provider's right to file an appeal of the MCO action through the MCO;

(4) the member's right to request an HSD fair hearing and what the process would be;

(5) the procedures for exercising the rights specified;

(6) the circumstances under which expedited resolution of an appeal is available and how to request it;

(7) the member's right to have benefits continue pending resolution of an appeal, how to request the continuation of benefits, and the circumstances under which the member may be required to pay the costs of continuing these benefits.

C. A member may file an appeal of an MCO action within 90 calendar days of receiving the MCO's notice of action. The legal guardian of the member for minors or incapacitated adults, a representative of the member as designated in writing to the MCO, or a provider acting on behalf of the member with the member's written consent, have the right to file an appeal of an action on behalf of the member.

D. The MCO has thirty (30) calendar days from the date the oral or written appeal is received by the MCO to resolve the appeal.

E. The MCO shall have a process in place that that assures that an oral inquiry from a member seeking to appeal an action is treated as an appeal (to establish the earliest possible filing date for the appeal). An oral appeal must be followed by a written appeal within 10 calendar days that is signed by the member. The MCO

will make best efforts to assist members as needed with the written appeal.

F. Within five (5) working days of receipt of the appeal, the MCO shall provide the grievant with written notice that the appeal has been received and the expected date of its resolution. The MCO shall confirm in writing receipt of oral appeals, unless the member or the provider requests an expedited resolution.

G. The MCO has thirty (30) calendar days from the date the oral or written appeal is received by the MCO to resolve the appeal.

H. The MCO may extend the thirty 30-day timeframe by 14 calendar days if the member requests the extension, or the MCO demonstrates to HSD that there is need for additional information, and the extension is in the member's interest. For any extension not requested by the member, the MCO must give the member written notice of the extension and the reason for the extension within two (2) working days of the decision to extend the timeframe.

I. The MCO shall provide the member and/or the member's representative a reasonable opportunity to present evidence, and allegations of the fact or law, in person as well as in writing.

J. The MCO shall provide the member and/or the representative the opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process. The MCO shall include as parties to the appeal the member and his or her representative, or the legal representative of a deceased member's estate.

K. For all appeals, the MCO shall provide written notice within the thirty 30-calendar-day timeframe of the appeal resolution to the member or the provider, if the provider filed the appeal.

(1) The written notice of the appeal resolution must include, but not be limited to, the following information:

(a) the result(s) of the appeal resolution; and

(b) the date it was completed.

(2) The written notice of the appeal resolution for appeals not resolved wholly in favor of the member must include, but not be limited to, the following information:

(a) the right to request an HSD fair hearing and how to do so;

(b) the right to request receipt of benefits while the hearing is pending, and how to make the request; and

(c) that the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's action.

L. The MCO may continue benefits while the appeal and/or the HSD fair hearing process is pending.

(1) The MCO must continue the member's benefits if all of the following are met:

(a) The member or the provider files a timely appeal of the MCO action (within 10 days of the date the MCO mails the notice of action);

(b) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(c) The services were ordered by an authorized provider;

(d) The time period covered by the original authorization has not expired; and

(e) The member requests extension of the benefits.

(2) The MCO shall provide benefits until one of the following occurs:

(a) The member withdraws the appeal;

(b) Ten days have passed since the date the MCO mailed the resolution letter, providing the resolution of the appeal was against the member and the member has taken no further action;

(c) HSD issues a hearing decision adverse to the member;

(d) The time period or service limits of a previously authorized service has expired.

(3) If the final resolution of the appeal is adverse to the member, that is, the MCO's action is upheld, the MCO may recover the cost of the services furnished to the member while the appeal was pending to the extent that services were furnished solely because of the requirements of this section, and in accordance with the policy in 42 CFR Section 431.230(b).

(4) If the MCO or HSD reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

(5) If the MCO or HSD reverses a decision to deny, limit or delay services and the member received the disputed services while the appeal was pending, the MCO must pay for these services.

[8.305.12.12 NMAC - Rp 8.305.12.12 NMAC, 7-1-04]

8.305.12.13 EXPEDITED RESOLUTION OF APPEALS: An expedited resolution of an appeal is an expedited review by the MCO of an MCO action.

A. The MCO shall establish and maintain an expedited review process for appeals when the MCO determines that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Such a determination is based on:

(1) a request from the member;

(2) a provider's support of the member's request;

(3) a provider's request on behalf of the member; or

(4) the MCO's independent determination.

B. The MCO shall ensure that the expedited review process is convenient and efficient for the member.

C. The MCO shall resolve the appeal within three (3) working days of receipt of the request for an expedited appeal, if the request meets the definition of expedited.

D. The MCO may extend the timeframe by up to 14 calendar days if the member requests the extension, or the MCO demonstrates to HSD that there is need for additional information and the extension is in the member's interest. For any extension not requested by the member, the MCO shall give the member written notice of the reason for the delay.

E. The MCO shall ensure that punitive action is not taken against a member or a provider who requests an expedited resolution or supports a member's expedited appeal.

F. The MCO shall provide expedited resolution if the request meets the definition of an expedited appeal in response to an oral or written request from the member or provider on behalf of the member.

G. The MCO shall inform the member of the limited time available to present evidence and allegations in fact or law.

H. If the MCO denies a request for an expedited resolution of an appeal, it shall:

(1) transfer the appeal to the thirty (30)-day timeframe for standard resolution, in which the 30-day period begins on the date the MCO received the request;

(2) make reasonable efforts to give the member prompt oral notice of the denial, and follow up with a written notice within two (2) calendar days; and

(3) inform the member in the written notice of the right to file an appeal and/or request an HSD fair hearing if the member is dissatisfied with the MCO's decision to deny an expedited resolution.

I. The MCO shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.

[8.305.12.13 NMAC - Rp 8.305.12.12 NMAC, 7-1-04]

8.305.12.14 SPECIAL RULE

FOR CERTAIN EXPEDITED SERVICE AUTHORIZATION DECISIONS: In the case of expedited service authorization decisions that deny or limit services, the MCO shall, within 72 hours of receipt of the request for service, automatically file an appeal on behalf of the member, make a best effort to give the member oral notice of the decision on the automatic appeal, and make a best effort to resolve the appeal.
[8.305.12.14 NMAC - Rp 8.305.12.13 NMAC, 7-1-04]

8.305.12.15 OTHER RELATED MCO PROCESSES:

A. **Information about grievance system to providers and subcontractors**: The MCO must provide information specified in 42 CFR Section, 438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.

B. **Grievance and/or appeal files:**

(1) All grievance and/or appeal files shall be maintained in a secure and designated area and be accessible to HSD, upon request, for review. Grievance and/or appeal files shall be retained for six (6) years following the final decision by the MCO, HSD, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later.

(2) The MCO will have procedures for assuring that files contain sufficient information to identify the grievance and/or appeal, the date it was received, the nature of the grievance and/or appeal, notice to the member of receipt of the grievance and/or appeal, all correspondence between the MCO and the member, the date the grievance and/or appeal is resolved, the resolution, and notices of final decision to the member and all other pertinent information.

(3) Documentation regarding the grievance shall be made available to the member, if requested.
[8.305.12.15 NMAC - Rp 8.305.12.15 NMAC, 7-1-04]

8.305.12.16 MCO PROVIDER GRIEVANCE PROCESS: An MCO shall establish and maintain written policies and procedures for the filing of provider grievances. A provider shall have the right to file a grievance with the MCO regarding utilization management decisions and/or provider payment issues. Grievances shall be resolved within 30 calendar days. A provider may not file a grievance on behalf of a member without written designation by the member as the member's representative. See 8.305.12.13 for special rules for certain expedited service authorizations.
[8.305.12.16 NMAC - Rp 8.305.12.17 NMAC, 7-1-04]

HISTORY OF 8.305.12 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:
8 NMAC 4.MAD.606.11, Managed Care Policies, Grievance Resolution, 6-19-97.

History of Repealed Material:
8 NMAC 4.MAD.606.11, Managed Care Policies, Grievance Resolution - Repealed, 7-1-01.
8.305.12 NMAC, Medicaid Managed Care, MCO Member Grievance Resolution - Repealed 7-1-04.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 15 SERVICES FOR INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS

8.305.15.1 ISSUING AGENCY: Human Services Department
[8.305.15.1 NMAC - Rp 8.305.15.1 NMAC, 7-1-04]

8.305.15.2 SCOPE: This rule applies to the general public.
[8.305.15.2 NMAC - Rp 8.305.15.2 NMAC, 7-1-04]

8.305.15.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.305.15.3 NMAC - Rp 8.305.15.3 NMAC, 7-1-04]

8.305.15.4 DURATION: Permanent
[8.305.15.4 NMAC - Rp 8.305.15.4 NMAC, 7-1-04]

8.305.15.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.305.15.5 NMAC - Rp 8.305.15.5 NMAC, 7-1-04]

8.305.15.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid managed care program.
[8.305.15.6 NMAC - Rp 8.305.15.6 NMAC, 7-1-04]

8.305.15.7 DEFINITIONS: See 8.305.1.7 NMAC.
[8.305.15.7 NMAC - Rp 8.305.15.7 NMAC, 7-1-04]

8.305.15.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.305.15.8 NMAC - Rp 8.305.15.8 NMAC, 7-1-04]

8.305.15.9 SERVICES FOR INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS (ISHCN):

A. ISHCN require a broad range of primary, specialized medical, behavioral health and related services. ISHCN have ongoing health conditions, high or complex service utilization, and low to severe functional limitations. The primary purpose of the definition is to identify these individuals so that the MCO can facilitate access to appropriate services. The definition also allows for flexible targeting of individuals based on clinical justification and discontinuing targeted efforts when such efforts are no longer needed.

B. **Identification of enrolled ISHCN:** The MCO shall have written policies and procedures in place with HSD approval, which govern how members with multiple and complex physical and behavioral health care needs shall be identified. The MCOs shall have an internal operational process, in accordance with policy and procedure, to target members for the purpose of applying stratification criteria to identify ISHCNs. The MCO shall employ reasonable effort to identify ISHCNs based at least on the following criteria:

(1) individuals eligible for SSI;

(2) individuals enrolled in the home-based waiver programs;

(3) children receiving foster care or adoption assistance support;

(4) individuals identified by service utilization, clinical assessment, or diagnosis; and

(5) referral by family or a public or community program.
[8.305.15.9 NMAC - Rp 8.305.15.9 NMAC, 7-1-04]

8.305.15.10 SALUD! ENROLLMENT FOR ISHCN:

A. **Switch enrollment:** Members, including ISHCN, may request to break a lock-in and be switched to membership in another MCO, based on cause. The member, the member's family or legal guardian shall contact HSD to request that

the member be switched to another MCO. The MCO shall have policies and procedures to facilitate a smooth transition of a member who switches enrollment to another MCO. See Subsection F of 8.305.5.9 NMAC, *Member Switch Enrollment*.

B. **ISHCN information and education:**

(1) The MCO shall develop and distribute to ISHCN members, caregivers, parents and/or legal guardians, as appropriate, information and materials specific to the needs of this population. This includes information, such as items and services that are provided or not provided by the Salud! program, information about how to arrange transportation, and which services require a referral from the PCP. The individual, family, caregiver, or legal guardian shall be informed on how to present an individual for care in an emergency room that is unfamiliar with the individual's special health care needs and about the availability of care coordination. See 8.305.9 NMAC, *Coordination of Services*. This information may be included in a special member handbook or in an ISHCN insert to the member handbook.

(2) The MCO shall provide health education information to assist an ISCHN and/or caregivers in understanding how to cope with the day-to-day stress caused by chronic illness.

(3) The MCO shall provide ISHCNs and/or caregivers a list of key MCO resource people and their telephone numbers. The MCO shall designate a single point of contact that an ISHCN, family member, caregiver, or provider may call for information.

[8.305.15.10 NMAC - Rp 8.305.15.10 NMAC, 7-1-04]

8.305.15.11 CHOICE OF SPECIALIST AS PCP: The MCO shall develop and implement policies and procedures governing the process for member selection of a PCP, including the right by an ISHCN to choose a specialist as a PCP. The specialist provider must agree to be the PCP.

[8.305.15.11 NMAC - Rp 8.305.15.11 NMAC, 7-1-04]

8.305.15.12 SPECIALTY PROVIDERS FOR (ISHCN): The MCO shall have policies and procedures in place to allow direct access to necessary specialty care, consistent with Salud! access appointment standards for clinical urgency. See 8.305.8.18 NMAC, S*tandards for Access*.

[8.305.15.12 NMAC - Rp 8.305.15.12 NMAC, 7-1-04]

8.305.15.13 TRANSPORTATION FOR (ISHCN): The MCO shall:

A. have written policies and procedures in place to ensure that the appropriate level of transportation is arranged, based on the individual's clinical condition;

B. have past member service data available at the time services are requested to expedite appropriate arrangement;

C. ensure that CPR-certified drivers transport ISHCN if clinically indicated;

D. have written policies and procedures to ensure that the transportation mode is clinically appropriate, including access to non-emergency ground carriers;

E. develop and implement written policies and procedures to ensure that individuals can access and receive authorization for needed transportation services under certain unusual circumstances without the usual advance notification;

F. develop and implement a written policy regarding the transportation of minors to ensure the minor's safety; and

G. distribute clear and detailed written information to ISHCN and, if needed, their caregivers, on how to obtain transportation services and also make this information available to network providers.

[8.305.15.13 NMAC - Rp 8.305.15.13 NMAC, 7-1-04]

8.305.15.14 CARE COORDINATION FOR ISHCN: The MCOs shall develop policies and procedures to provide care coordination for ISHCN. Please refer to Section 8.305.9.9 NMAC, *Coordination of Services*, for definition.

A. The MCO shall have an internal operational process, in accordance with policy and procedure, to target medicaid members for purposes of applying stratification criteria to identify those who are potential ISHCN. The contractor will provide HSD with the applicable policy and procedure describing the targeting and stratification process.

B. The MCO shall have written policies and procedures to ensure that each member identified as having special health care needs is assessed by an appropriate health care professional regarding the need for care coordination.

C. The MCO shall have written policies and procedures for educating ISHCN needs and, in the case of children with special health care needs, parent(s), legal guardians, that care coordination is available and when it may be appropriate to their needs.

[8.305.15.14 NMAC - Rp 8.305.15.14 NMAC, 7-1-04]

8.305.15.15 EMERGENCY, INPATIENT AND OUTPATIENT AMBULATORY SURGERY HOSPITAL REQUIREMENTS FOR ISHCN: The MCO shall develop and implement policies and procedures for:

A. educating ISHCN, ISHCN's family members and/or caregivers with complicated clinical histories on how to access emergency room care and what clinical history to provide when emergency care or inpatient admission is needed;

B. how coordination with the PCP and the hospitalist shall occur when an ISHCN is hospitalized;

C. ensuring that the emergency room physician has access to the individual's medical history; and

D. obtaining any necessary referrals from PCPs for inpatient hospital staff providing outpatient or ambulatory surgical procedures.

[8.305.15.15 NMAC - Rp 8.305.15.15 NMAC, 7-1-04]

8.305.15.16 REHABILITATION THERAPY SERVICES (PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY) FOR ISHCN: The MCO shall:

A. develop and implement therapy using clinical practice guidelines specific to acute, chronic or long-term conditions of their ISHCN that meet medical necessity criteria and are based on HSD's children and adult rehabilitation services policy;

B. be knowledgeable about and coordinate with the home and community-based waiver programs and/or the schools regarding other therapy services being provided to the ISHCN in order to avoid duplication of services;

C. involve the ISHCN's family, caregivers, physicians and therapy providers in identifying issues to be included in the plan of care; and

D. develop and implement utilization prior approval and continued stay criteria, including time frames, that are appropriate to the chronicity of the member's status and anticipated development process.

[8.305.15.16 NMAC - Rp 8.305.15.16 NMAC, 7-1-04]

8.305.15.17 DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES FOR ISHCN: The MCO shall:

A. develop and implement a process to permit members utilizing supplies on an ongoing basis to submit a list of supplies to the DME provider on a monthly basis; the MCO shall contact the member or the member's legal guardian or caregiver when requested supplies cannot be delivered and make other arrangements, consis-

tent with clinical need;

B. develop and implement a system for monitoring compliance with access standards for DME and medical supplies, and institute corrective action if the provider is out of compliance; and

C. have an emergency response plan for DME and medical supplies needed on an emergent basis.

[8.305.15.17 NMAC - Rp 8.305.15.17 NMAC, 7-1-04]

8.305.15.18 CLINICAL PRACTICE GUIDELINES FOR PROVISION OF CARE TO (ISHCN): The MCO shall develop clinical practice guidelines, practice parameters and other criteria that consider the needs of ISHCN and provide guidance in the provision of acute and chronic medical and behavioral health care services to this population. The guidelines should be based on professionally accepted standards of practice and national guidelines.

[8.305.15.18 NMAC - Rp 8.305.15.18 NMAC, 7-1-04]

8.305.15.19 UTILIZATION MANAGEMENT (UM) FOR SERVICES TO (ISHCN): The MCO shall develop written policies and procedures to exclude from prior authorization any item of service identified in the course of treatment, and/or extend the authorization periodicity for services provided for chronic conditions. There shall be a process for review and periodic update for the course of treatment, as indicated.

[8.305.15.19 NMAC - Rp 8.305.15.19 NMAC, 7-1-04]

8.305.15.20 ADDITIONS TO CONSUMER ASSESSMENT OF HEALTH PLANS SURVEY (CAHPS) FOR (ISHCN): The MCO shall add questions about ISHCN to the most current HEDIS CAHPS survey.

[8.305.15.20 NMAC - Rp 8.305.15.20 NMAC, 7-1-04]

8.305.15.21 ISHCN PERFORMANCE MEASURES: The MCO shall initiate a performance measure specific to ISHCN. See 8.305.8 NMAC, *Quality Management*.

[8.305.15.21 NMAC - Rp 8.305.15.21 NMAC, 7-1-04]

HISTORY OF 8.305.15 NMAC:

History of Repealed Material:

8.305.15 NMAC, Services For Children With Special Health Care Needs - Repealed 7-1-04.

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 11 PODIATRY SERVICES

8.310.11.1 ISSUING AGENCY: New Mexico Human Services Department.

[8.310.11.1 NMAC - Rp, 8 NMAC 4.MAD.000.1, 7/1/04]

8.310.11.2 SCOPE: The rule applies to the general public.

[8.310.11.2 NMAC - Rp, 8 NMAC 4.MAD.000.2, 7/1/04]

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

[8.310.11.3 NMAC - Rp, 8 NMAC 4.MAD.000.3, 7/1/04]

8.310.11.4 DURATION: Permanent

[8.310.11.4 NMAC - Rp, 8 NMAC 4.MAD.000.4, 7/1/04]

8.310.11.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.

[8.310.11.5 NMAC - Rp, 8 NMAC 4.MAD.000.5, 7/1/04]

8.310.11.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[8.310.11.6 NMAC - Rp, 8 NMAC 4.MAD.000.6, 7/1/04]

8.310.11.7 DEFINITIONS: [RESERVED]

8.310.11.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[8.310.11.8 NMAC - Rp, 8 NMAC 4.MAD.002, 7/1/04]

8.310.11.9 PODIATRY SERVICES: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients. To help New Mexico recipients receive necessary services, MAD pays for covered services furnished by podiatrists. This part describes eligible podiatric providers, types of services furnished by podiatrists that are covered by medicaid and general reimbursement methodology.

[8.310.11.9 NMAC - Rp, 8 NMAC 4.MAD.718.2, 7/1/04]

8.310.11.10 ELIGIBLE PROVIDERS:

A. Upon MAD's approval of New Mexico medical assistance program provider participation applications licensed practitioners or facilities that meet applicable requirements are eligible to be reimbursed for furnishing covered services to medicaid recipients. Providers must be enrolled as medicaid providers before submitting a claim for payment to MAD claims processing contractor.

B. Once enrolled, providers receive and are responsible for maintenance of, a packet of information which includes medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. To be eligible for medicaid reimbursement, providers are bound by MAD policies, procedures, billing instructions, reimbursement rates, and all audit, recoupment and withhold provisions unless superceded by federal law, federal regulation or the specific written approval of the MAD director.

C. The "practice of podiatry" is defined as engaging in that primary health care profession, the members of which examine, diagnose, treat, and prevent by medical, surgical and mechanical means ailments affecting the human foot and ankle and the structures governing their functions, but does not include amputation of the foot or the personal administration of a general anesthetic. See NMSA 1978 Section 61-8-2 (Repl. Pamp. 1991).

[8.310.11.10 NMAC - Rp, 8 NMAC 4.MAD.718.21, 7/1/04]

8.310.11.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS: Providers who furnish services to medicaid recipients agree to comply with all federal and state laws and regulations relevant to the provision of medical services, including but not limited to, Title XIX of the Social Security Act, the Medicare and Medicaid Anti-Fraud Act, and the state Medicaid Fraud Act. Providers also agree to conform to MAD policies and instructions as specified in this manual and its

appendices, as updated.

A. **Recipient eligibility determination:** Providers must verify that services they furnish are provided to eligible recipients.

(1) Providers may verify eligibility through several mechanisms, including the use of an automated voice response system, contacting the medicaid fiscal agent contractor eligibility help desk, contracting with a medicaid eligibility verification system (MEVS) vendor, or contracting with a medicaid magnetic swipe card vendor. Providers must verify that recipients are eligible and remain eligible for medicaid throughout periods of continued or extended services. By verifying client eligibility, a provider is informed of restrictions that may apply to a recipient's eligibility.

(2) A recipient becomes financially responsible for a provider claim if the recipient fails to furnish identification before service and MAD denies payment because of the resulting administrative error. Settlement of these claims is between the provider and recipient.

B. **Requirements for updating information:** Providers must furnish MAD or the MAD claims processing contractor with complete information on changes in their address, license, certification, board specialties, corporate name or corporate ownership, and a statement as to the continuing liability of the provider for any recoverable obligation to MAD which occurred or may have occurred prior to any sale, merger, consolidation, dissolution or other disposition of the health care provider or person. MAD or the MAD claims processing contractor must receive this information at least 60 days before the change. Any payment made by MAD based upon erroneous or outdated information is subject to recoupment.

C. **Documentation requirements:** Providers must maintain records to fully disclose the nature, quality, amount, and medical necessity of services furnished to recipients who are currently receiving or who have received medical services in the past [42 CFR 431.107(b)]. Documentation supporting medical necessity must be legible and available to medicaid upon request.

(1) For foot care services covered by virtue of systemic disease, documentation of the clinical condition of the feet should contain sufficient detail to provide evidence that non-professional performance of the service would have been hazardous for the recipient. The recipient's records must include the following:

(a) a clinical description of the feet. Simply listing class findings is insufficient.

(b) description of co-morbid conditions such as infections or abscesses.

(c) documentation of appropriate attempts to alleviate conditions that contribute to foot problems.

(2) To the extent that management of an underlying systemic disease impacts the need for and/or expected outcome of management of the feet, the status of the systemic disease should be recorded. Documentation is to be repeated in the record as often as necessary to accurately portray the recipient's current condition at the time of billed services.

(3) For recipients whose foot care is covered due to the presence of a systemic condition that requires active treatment, documentation by the treating physician is to include corroboration of the systemic condition diagnosis and active treatment of the systemic disease.

(4) Documentation of foot care services to residents of nursing homes must include a current nursing facility order (dated and signed with date of signature) for routine foot care service, issued by the patient's supervising physician, that describes the specific service necessary. Such orders must meet the following requirements:

(a) The order must be dated and must have been issued by the supervising physician prior to foot care services being rendered.

(b) Telephone or verbal orders not written personally by the supervising physician must be authenticated by the dated physician's signature within 30 days following the issuance of the order.

(c) The order must be consistent with the attending physician's plan of care. The order must be for medically necessary services to address a specific patient complaint or physical finding.

(d) Routinely issued or "standing" facility orders for routine foot care service and orders for non-specific podiatric services that do not meet the above requirements are insufficient.

(e) Documentation of foot care services to residents of nursing homes performed solely at the request of the patient or patient's family/conservator must include the identity of the person who requested the services and that person's relationship to the patient.

(5) The patient's record must include the location of each lesion treated and specific mention (by number or name) and description of each nail treated.

(6) For foot care services for recipients with diabetic sensory neuropathy and loss of protective sensation (LOPS), the patient history should include, but is not limited to, how, when and by whom the diagnosis of LOPS was made, as well as any pertinent present and/or past history regarding the feet.

(7) The recipient's history should include, at the least, an interval history regarding the feet since the previous evaluation for follow-up physician evaluation and management of a patient with diabetic sensory neuropathy resulting in a LOPS.

(8) For coverage of mycotic nail debridement by reason of the presence of specified conditions, that is, in the absence of a qualifying systemic condition, the medical record should document the following:

(a) patient's description of the pain including such things as severity, duration, contextual information, modifying factors, specification regarding which nail(s) is painful, etc.

(b) description of patient's functional limitation due to the nail(s).

(c) description of any secondary infections.

(d) description of other modalities of treatment to which debridement or other surgical procedure is adjunctive (in the event that pharmacologic therapy is contraindicated or otherwise not indicated, the nature of the contraindication should be described).

(9) Debridement must be distinguished from trimming or clipping and records supporting each billed debridement should indicate what portion of the nail was not attached to the nail bed and what portion of the nail was removed.

(10) Services not substantiated in the recipient's records are subject to recoupment. See 8.351.2 NMAC, *Sanctions And Remedies*.

[8.310.11.11 NMAC - Rp, 8 NMAC 4.MAD.718.22, 7/1/04]

8.310.11.12 COVERED SERVICES: Medicaid covers only medically necessary podiatric services furnished by providers, as required by the condition of the recipient. All services must be furnished within the scope and practice of the podiatrist as defined by state law, the New Mexico board of podiatry licensing requirements, and in accordance with applicable federal, state, and local laws and regulations. Medicaid covers the following specific podiatry services:

A. Routine foot care when there is evidence of a systemic condition, circulatory distress or areas of diminished sensation in the feet demonstrated through physical or clinical determination and if the severity meets the class findings (as in Subparagraphs (a) through (c) of Paragraph (2) of Subsection A of 8.310.11.12 NMAC). Patients with diagnoses marked by an asterisk(*) in the list below must be under the active care of an M.D. or D.O. to qualify for covered routine foot care, and must have been assessed by that provider for the spec-

ified condition within six months prior to or 60 days after the routine foot care service. Nurse practitioners, physician assistants and clinical nurse specialists do not satisfy the coverage condition of "active care by a physician".

(1) The following list of systemic diseases is not all-inclusive and represents the most commonly billed diagnoses which qualify for medically necessary foot care:

(a) diabetes mellitus*;

(b) arteriosclerosis obliterans;

(c) buerger's disease;

(d) chronic thrombophlebitis*;

(e) neuropathies involving the feet associated with:

(i) malnutrition and vitamin deficiency*;

(ii) malnutrition (general, pellagra);

(iii) alcoholism;

(iv) malabsorption (celiac disease, tropical sprue);

(v) pernicious anemia;

(vi) carcinoma*;

(vii) diabetes mellitus*;

(viii) drugs or toxins*;

(ix) multiple sclerosis*;

(x) uremia (chronic renal disease)*;

(xi) traumatic injury;

(xii) leprosy or neurosyphilis;

(xiii) hereditary disorders;

(xiv) hereditary sensory radicular neuropathy;

(x) fabry's disease;

(xvi) amyloid neuropathy.

(2) Routine foot care services can be covered for patients who have a systemic condition that can be covered (as in Subparagraphs (a) through (e) of Paragraph (1) of Subsection A of 8.310.11.12 NMAC) and if the severity meets the class findings as follows: one of class A findings; or two of class B findings; or one of the class B findings and two of the following class C findings:

(a) **Class A findings:** non-traumatic amputation of foot or integral skeletal portion thereof.

(b) **Class B findings:**

(i) absent posterior tibial pulse;

(ii) absent dorsalis pedis pulse;

(iii) advanced trophic changes as evidenced by any three of the following: hair growth (decrease or increase); nail changes (thickening); pigmentary changes (discoloring); skin texture (thin, shiny); and/or skin color (rubor or redness).

(c) **Class C findings:**

(i) claudication;

(ii) temperature changes (e.g., cold feet);

(iii) edema;

(iv) paresthesias (abnormal spontaneous sensations in the feet); and/or

(v) burning.

B. Surgical correction of a subluxated foot structure that is an integral part of the treatment of foot pathology or that is undertaken to improve the function of the foot or to alleviate an associated symptomatic condition, including treatment of bunions, is covered when a recipient meets the systemic conditions and class findings as required for routine foot care. See Subparagraphs (a) through (c) of Paragraph (2) of Subsection A of 8.310.11.12 NMAC. Treatment for bunions is limited to capsular and/or bony surgery. The treatment of subluxation of the foot is defined as partial disclocation or displacements of joint surfaces, tendons, ligaments or muscles in the foot.

C. Treatment of warts on the feet.

D. Treatment of asymptomatic mycotic nails may be covered in the presence of a systemic condition that meets the clinical findings and class findings as required for routine foot care. See Subparagraphs (a) through (c) of Paragraph (2) of Subsection A of 8.310.11.12 NMAC.

E. Treatment of mycotic nails is covered in the absence of a covered systemic condition if there is clinical evidence of mycosis of the toenail and one or more of the following conditions exist and results from the thickening and dystrophy of the infected nail plate:

(1) marked, significant limitation;

(2) pain; and/or

(3) secondary infection.

F. Orthopedic shoes and other supportive devices when the shoe is an integral part of a leg brace.

G. If the recipient has existing medical condition(s) that would predispose the recipient to complications even with minor procedures, hospitalization for the performance of certain outpatient podiatric services may be covered. All claims related to hospitalization for podiatric procedures are subject to pre-payment or post-payment review.

[8.310.11.12 NMAC - Rp, 8 NMAC 4.MAD.718.23, 7/1/04]

8.310.11.13 INJECTABLE DRUG SERVICES: Medicaid covers injectable medications administered by physicians or other healthcare providers furnishing services to eligible medicaid recipients within their scope of practice.

[8.310.11.13 NMAC - N, 7/1/04]

8.310.11.14 LABORATORY AND DIAGNOSTIC IMAGING SERVICES: Medicaid covers medically necessary laboratory and diagnostic imaging services ordered by practitioners and when furnished by medicaid providers to eligible medicaid recipients. See 42 CFR Section 440.30.

A. **Laboratory services:** Podiatrists can bill for medically necessary laboratory services ordered by podiatrists which are either rperformed by podiatrists or under their supervision. See 8.324.2 NMAC, *Laboratory Services*.

(1) Professional components associated with clinical laboratory services are payable only when the work is actually performed by pathologists who are not billing for global procedures and the work is for anatomic and surgical pathology only, including cytopathology, histopathology and bone marrow biopsies.

(2) Specimen collection fees are payable when obtained by venipuncture, arterial stick, or urethral catherization, unless recipients are inpatients of nursing facilities or hospitals.

B. **Diagnostic imaging services:** Podiatrists can bill for medically necessary diagnostic imaging or radiology services which are either performed by podiatrists or under their supervision. See 8.324.3 NMAC, *Diagnostic Imaging and Therapeutic Radiology Services* [MAD-752]

(1) The complete procedure includes the technical radiology component and the professional component.

(2) Medicaid covers one (1) professional component per imaging procedure.

(3) Reimbursement for imaging procedures includes all materials and minor services necessary to perform the procedure. Medicaid does not pay for kits, films, or supplies, as separate charges.

[8.310.11.14 NMAC - Rp, 8 NMAC 4.MAD.718.26, 7/1/04]

8.310.11.15 NONCOVERED SERVICES: Podiatric services are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services* [MAD-602]. Medicaid does not cover the following specific services or procedures:

A. Routine foot care is not covered except as indicated under "covered services" for recipients with systemic conditions meeting specified class findings. Routine foot care is defined as:

(1) trimming, cutting, clipping and debriding toenails;

(2) cutting or removal of corns,

calluses, and/or hyperkeratosis;

(3) other hygienic and preventative maintenance care such as cleaning and soaking of the feet, application of topical medications, and the use of skin creams to maintain skin tone in either ambulatory or bedfast patients.

(4) Any other service performed in the absence of localized illness, injury or symptoms involving the foot.

B. Services directed toward the care or correction of a flat foot condition. "Flat foot" is defined as a condition in which one or more arches of the foot have flattened out;

C. Orthopedic shoes and other supportive devices for the feet are generally not covered. This exclusion does not apply if the shoe is an integral part of a leg brace or therapeutic shoes furnished to diabetics.

D. Surgical or nonsurgical treatments undertaken *for the sole purpose* of correcting a subluxated structure in the foot as an isolated condition are not covered. Subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot.

E. Medicaid will not reimburse for services that have been denied by medicare for coverage limitations.

[8.310.11.15 NMAC - Rp, 8 NMAC 4.MAD.718.27, 7/1/04]

8.310.11.16 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished, before payment is made or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

A. Certain procedures or services can require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Prior authorization of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Providers who disagree with prior authorization request denials or other review decisions can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953].

[8.310.11.16 NMAC - Rp, 8 NMAC 4.MAD.718.28, 7/1/04]

8.310.11.17 REIMBURSEMENT:

A. Podiatrists must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing, and claims processing.

B. Reimbursement to providers is made at the lesser of the following:

(1) the provider's billed charge; or

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

(a) The provider's billed charge must be the provider's usual and customary charge for services.

(b) "Usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific procedure or service.

[8.310.11.17 NMAC - Rp, 8 NMAC 4.MAD.718.29, 7/1/04]

HISTORY OF 8.310.11 NMAC:

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

ISD 310.1100, Podiatry Services, filed 2/13/80.

ISD 310.1100, Podiatry Services, filed 10/14/81.

ISD Rule 310.1100, Podiatry Services, filed 2/28/83.

ISD Rule 310.1100, Podiatry Services, filed 2/21/86.

MAD Rule 310.11, Podiatry Services, filed 12/15/87.

MAD Rule 310.11, Podiatry Services, filed 4/27/88.

MAD Rule 310.11, Podiatry Services, filed 4/20/92.

History of Repealed Material:

MAD Rule 310.11, Podiatry Services, filed 4/20/92 - Repealed effective 2/1/95.

8 NMAC 4.MAD.718.2, Podiatry Services, filed 1/18/95 - Repealed effective 7/1/04.

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

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

8.315.4.1 ISSUING AGENCY: New Mexico Human Services Department.

[8.315.4.1 NMAC - Rp 8 NMAC 4.MAD.000.1, 7/1/04]

8.315.4.2 SCOPE: The rule applies to the general public.

[8.315.4.2 NMAC - Rp 8 NMAC 4.MAD.000.2, 7/1/04]

8.315.4.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).

[8.315.4.3 NMAC - Rp 8 NMAC 4.MAD.000.3, 7/1/04]

8.315.4.4 DURATION: Permanent

[8.315.4.4 NMAC - Rp 8 NMAC 4.MAD.000.4, 7/1/04]

8.315.4.5 EFFECTIVE DATE: July 1, 2004 unless a later date is cited at the end of a section.

[8.315.4.5 NMAC - Rp 8 NMAC 4.MAD.000.5, 7/1/04]

8.315.4.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[8.315.4.6 NMAC - Rp 8 NMAC 4.MAD.000.6, 7/1/04]

8.315.4.7 DEFINITIONS: [RESERVED]

8.315.4.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[8.315.4.8 NMAC - Rp 8 NMAC 4.MAD.002, 7/1/04]

8.315.4.9 PERSONAL CARE OPTION SERVICES: Personal care option (PCO) is a program for qualified individuals 21 years of age or older who are eligible for full medicaid coverage, and meet the nursing facility (high or low NF) level of care criteria pursuant to 8.312.2 NMAC, *Nursing Facilities* [MAD-731]. It should be noted that personal care services for individuals under the age of 21 are reim-

bursed by the New Mexico medicaid program through the early periodic screening, diagnostic and treatment (EPSDT) services described in 8.323.2 NMAC, *EPSDT Personal Care Services*.

A. The goal of the PCO program is to avoid institutionalization, maintain or increase the individual's functional level and maintain or increase the individual's independence. The PCO program does not provide services 24 hours a day. PCO is a medicaid service, not a medicaid category, and services under this option are delivered pursuant to a personal care service plan (PCSP). PCO services include a range of services to consumers who are unable to perform some/all activities of daily living (ADLs) or independent activities of daily living (IADLs) because of a disability or a functional limitation(s). PCO services permit an individual to live in his or her home rather than an institution and allow him or her to maintain or increase independence. These services include, but are not limited to, bathing, dressing, grooming, eating, toileting, shopping, transporting, caring for assistance animals, cognitive assistance and communicating.

B. An individual may be physically capable of performing ADLs or IADLs but may have limitations in performing these activities because of a cognitive impairment. PCO services may be required because a cognitive impairment prevents an individual from knowing when or how to carry out the task. In such cases, personal care may include cueing along with supervision to ensure that the individual performs the task properly.

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

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

[8.315.4.9 NMAC - Rp 8 NMAC 4.MAD.738, 7/1/04]

8.315.4.10 CONSUMER-DIRECTED PERSONAL CARE: The consumer or the consumer's personal representative retains responsibility for performing employer-related tasks.

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

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

(a) verifying that the attendant possesses a current/valid New Mexico driver's license if there are any driving-related activities listed on the personal care service plan (PCSP); a copy of the driver's license must be in the attendant's personnel file;

(b) verifying that the attendant has proof of current liability automobile insurance if the consumer is to be transported in the attendant's vehicle at any time;

(c) identifying training needs for the attendants.

(2) developing a list of attendants who can be contacted when an unforeseen event occurs that prevents the consumer's regularly scheduled attendant from providing services;

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

(4) notifying the agency, within one (1) working day, of the date of hire and/or the date of termination of his/her attendant;

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

(6) ensuring that the elected individual for hire has submitted to a request for a nationwide criminal history screening, pursuant to 7.1.9 NMAC and in accord with NMSA 1978, Section 29-17-1 of the Caregivers Criminal History Screening Act, within 30 days of the individual beginning employment; the consumer must work with the elected agency to complete all paperwork required for submitting the nationwide criminal history screening; the consumer may conditionally (temporarily) employ the individual contingent upon the receipt of written notice of the nationwide criminal history screening; a consumer may not continue employing an attendant who does not successfully pass a nationwide criminal history screening; and

(7) obtaining from the attendant a signed agreement, in which the attendant agrees that he will not provide PCO services while under the influence of drugs and/or alcohol and acknowledges that if he is under the influence of drugs and/or alcohol while providing PCO services he will be immediately terminated; the consumer or his personal representative shall not employ an attendant who has previously been terminated from employment for use of drugs and/or alcohol while providing PCO services;

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

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

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

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

(3) maintaining records that are sufficient to fully disclose the extent and nature of the services furnished to the con-

sumers as outlined in 8.302.1 NMAC, *General Provider Policies*;

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

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

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

(7) maintaining appropriate record keeping of services provided and fiscal accountability as required by the MAD 312;

(8) ensuring that each consumer served has a current, approved PCSP on file;

(9) performing the necessary nationwide criminal history screening, pursuant to 7.1.9 NMAC and in accord with NMSA 1978, Section 29-17-1 of the Caregivers Criminal History Screening Act, on all potential personal care attendants; nationwide criminal history screenings must be performed by an agency certified to conduct such checks; the agency must work with the consumer to ensure the paperwork is submitted within the first 30 days of hire; consumers under the consumer-directed model may conditionally (temporarily) employ an attendant until such check has been returned from the certified agency; if the attendant does not successfully pass the nationwide criminal history screening, the consumer may not continue to employ the attendant;

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

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

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

(13) producing reports as required by the department;

(14) verifying that consumers will not be receiving services through the following programs while they are receiving PCO services: a medicaid home and community-based waiver (HCBW), medicaid nursing facility (NF), intermediate care facility/mentally retarded (ICF/MR), PACE, CYFD attendant care program, or medicaid hospice; an individual residing in a NF or ICF/MR or receiving community-based services is eligible to apply for PCO services; all individuals must meet the financial/medical eligibility requirements under the PCO program to receive PCO services; the third-party assessor, MAD, or its designee must conduct an assessment or evaluation to determine if the transfer is appropriate and if the PCO program would be able to meet the needs of that individual;

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

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

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

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

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

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

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

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

(b) evaluating methods of attendant competence and effectiveness.

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

(a) abuse, neglect and exploitation:

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

(ii) Neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness to a consumer.

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

(b) death:

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

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

(c) other reportable incidents:

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

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

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

primary care provider.

(23) obtaining from the consumer a signed contract with the attendant in which the attendant acknowledges that if he is under the influence of drugs and/or alcohol while providing PCO service, it will be grounds for immediate termination;

(24) maintaining a consumer file and an attendant personnel file for the consumer.

C. **Eligible consumer-directed agencies:** Personal care agencies must be certified by MAD or its designee. (A detailed guideline for all of the requirements can be obtained through MAD's fiscal agent.) To be certified by MAD or its designee, agencies must meet the following conditions and submit a packet (contents 1-5 described below) for approval to MAD's fiscal agent or its designee containing the following:

(1) a completed medicaid provider participation application (MAD 312);

(2) copies of successfully passed nationwide caregivers criminal history screenings on employees who meet the definition of "caregiver" and "care provider" pursuant to 7.1.9 NMAC and in accord with NMSA 1978, Section 29-17-1 of the Caregivers Criminal History Screening Act;

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

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

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

(a) MAD's personal care option provider policies;

(b) personnel policies; and

(c) office requirements.

(i) Agencies must establish and maintain an official office for the conduct of business with posted hours of operation and a published phone number. Branch offices must be within a one hundred (100) mile radius of the agency's main office's physical location. In order to ensure the health and safety of consumer, the main agency can service up to a one hundred (100) mile radius of the agency's physical location. The satellite office can also service up to one hundred (100) mile radius of its actual physical location.

(ii) Agencies offices must meet all Americans with Disabilities Act (ADA) requirements.

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

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

(i) service delivery;

(ii) operational activities;

(iii) quality improvement action plan; and

(iv) documentation of activities.

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

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

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

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

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

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

(1) being hired by the consumer;

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

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

(4) being 18 years of age or older;

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

(6) successfully passing a nationwide criminal history screening, pursuant to 7.1.9 NMAC and in accord with NMSA 1978, Section 29-17-1 of the Caregivers Criminal History Screening Act, performed by an agency certified to conduct such checks; attendants are required to submit to a criminal history screening within the first 30 days of hire; an attendant may be conditionally (temporarily) hired by the consumer contingent upon the receipt of written notice of the nationwide criminal history screening; attendants who do not successfully pass a nationwide criminal history screening are not eligible for continued employment under the PCO program.

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

[8.315.4.10 NMAC - Rp 8 NMAC 4.MAD.738.1, 7/1/04]

8.315.4.11 CONSUMER-DELEGATED PERSONAL CARE: The agency contracts with the department to perform employer-related tasks.

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

(1) employing, terminating and scheduling qualified attendants;

(2) training all attendants for a minimum of twelve (12) hours per year; initial training must be completed within the first three (3) months of employment and must encompass:

(a) an overview of the PCO program;

(b) living with a disability in the community;

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

(d) a written competency test with a minimum passing score of seventy-five (75%) or better; expenses for all trainings are to be incurred by the agency; other trainings may take place throughout the year as determined by the agency; the agency must maintain in the attendant's file copies of all trainings, certifications, and specialty training the attendant completed. CPR and first aid certifications must be kept current;

(i) documentation of all

training must include at least the following information: 1) name of individual taking training; 2) title, purpose, and objectives of class; 3) name of instructor; 4) number of hours of instruction; 5) date instruction was given;

(ii) documentation of competency testing must include at least the following: 1) name of individual being evaluated for competency; 2) date and method used to determine competency; 3) copy of the attendant's competency test in the attendant's personnel file.

(3) submitting to the department of health (DOH) for inclusion on the PCO attendant registry names of all qualified PCO attendants who have completed the required training and competency testing per subparagraphs (a) through (d) of Paragraph (2) of Subsection A of 8.315.4 NMAC; the agency must verify with DOH that PCO attendants previously employed by other PCO agencies are in good standing with DOH on the PCO attendant registry and cannot employ attendants who are not in good standing;

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

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

(6) providing the attendant with information on community resources and information about the specific populations being served;

(7) obtaining a copy of the attendant's current/valid New Mexico driver's license and a copy of the motor vehicle insurance policy if the consumer is to be transported by the attendant; copies of the driver's license and motor vehicle insurance policy must be maintained in the attendant's personnel file;

(8) complying with federal and state regulations and labor laws.;

(9) preparing all documentation necessary for payroll; and

(10) producing reports as required by the department.

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

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

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

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

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

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

(17) maintaining appropriate record keeping of services provided and fiscal accountability as required by the MAD 312;

(18) ensuring that each consumer served has a current, approved PCSP on file;

(19) performing the necessary nationwide criminal history screening, pursuant to 7.1.9 NMAC and in accord with NMSA 1978, Section 29-17-1 of the Caregivers Criminal History Screening Act; the agency must ensure that the individual has submitted to a request for a nationwide criminal history screening within 30 days of the individual beginning employment; nationwide criminal history screening must be performed by an agency certified to conduct such checks; agencies under the consumer-delegated model may conditionally (temporarily) employ an attendant until the nationwide criminal history screening has been returned from the certified agency; if the attendant does not successfully pass a nationwide criminal history screening, the agency may not continue employment;

(20) obtaining from the attendant a signed agreement, in which the attendant agrees that he will not provide PCO services while under the influence of drugs and/or alcohol and acknowledges that if he is under the influence of drugs and/or alcohol while providing PCO services he will be immediately terminated; the agency shall not employ an attendant who has previously been terminated from employment for use of drugs and/or alcohol while providing PCO services;

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

(22) producing reports as required by the department;

(23) verifying that consumers will not be receiving services through the following programs, while they are receiving PCO services: a medicaid home and community-based waiver (HCBW), medicaid nursing facility (NF), intermediate care facility/mentally retarded (ICF/MR), PACE, CYFD attendant care program, or medicaid hospice; an individual residing in a NF or ICF/MR or receiving community-based services is eligible to apply for PCO services; all individuals must meet the financial/medical eligibility requirements under the PCO program to receive PCO services; the third-party assessor, MAD, or its designee must conduct an assessment or evaluation to determine if the transfer is appropriate and if the PCO program would be able to meet the needs of that individual;

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

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

(26) establishing and explaining to all their consumers and all attendants the necessary payroll documentation needed for reimbursement of PCO services, such as time sheets and tax forms;

(27) performing payroll activities

for the attendants, such as, but not limited to income tax and social security withholdings;

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

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

(30) submitting written incident reports to MAD or its designee, by fax, within 24 hours of the incident being reported to the agency; reportable incidents may include, but are not limited to:

(a) abuse, neglect and exploitation:

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

(ii) Neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness to a consumer.

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

(b) death:

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

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

(c) other reportable incidents:

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

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

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

(31) conducting supervisory visits in the consumer's home, once a month at a minimum, which must include a face-to-face interview with the consumer, and/or his/her personal representative;

(32) documenting in the consumer's file the safety of the service and the quality of care provided to the consumer;

(33) arranging regular staff meetings and in-service training programs for attendants; agencies must bear expenses for all trainings but is not required to pay attendants for his/her training time; attendants must receive a minimum of 12 hours training per year, which must include CPR and first aid and should be in-conjunction with the consumers needs; agencies must ensure CPR and first aid trainings are completed within the first three (3) months of employment; agencies must annually resubmit to DOH the names of all qualified PCO attendants upon completion of their annual in-service requirements; agencies must ensure that mandatory trainings are kept current and that copies of all trainings and certifications are in the attendant's personnel file;

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

(35) maintaining a roster of trained and qualified attendants for backup of regular scheduling and emergencies;

(36) offering hepatitis B immunization at the time of employment at no cost to the attendant and inform the attendant of the risks of hepatitis B infection; the attendant may refuse hepatitis B vaccination; documentation of current immunization, prior immunization, or refusal of immunization must be maintained in the attendant's personnel file;

(37) obtaining a current tuberculosis (TB) skin test or chest x-ray upon initial employment; TB testing must be conducted thereafter, pursuant to the current standards of the department of health; the results of the TB skin test or chest x-ray must be documented in the attendant's personnel file; if the individual tests positive for TB, he/she cannot be hired as an attendant; the individual must be referred to his/her physician or to the department of health for infectious disease treatment; when the individual has received appropriate treatment, he/she may be employed as the attendant; there must be documentation of treatment from a medical professional in the attendant's personnel file; the agency must incur expenses for TB tests; and

(38) conducting or arranging for a written competency test (approved by MAD or its designee as stated in Paragraph (6) of Subsection B of 8.315.4.11 NMAC of these regulations), at the agency's expense, for all eligible attendants; the attendant must successfully pass a written test with seventy-five percent (75%) or better within the first three (3) months of employment; a copy of the test must be in the attendant's personnel file; special accommodations must be made for attendants who are not able to read or write or who speak/read/write a language other than English;

B. **Eligible consumer-delegated agencies:** Personal care agencies must be certified by the MAD or its designee. (A detailed guideline to all of the requirements can be obtained through MAD's fiscal agent.) To be certified by MAD or its designee, agencies must meet the following conditions and submit a packet (contents 1-5 described below) for approval to MAD's fiscal agent or its designee containing the following:

(1) a completed medicaid provider participation application (MAD 312);

(2) copies of successfully passed caregivers criminal history screenings on employees who meet the definition of "caregiver" and "care provider" pursuant to 7.1.9 NMAC and in accord with the Caregivers Criminal History Screening Act;

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

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

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

(a) MAD's personal care option provider policies;

(b) personnel policies; and

(c) office requirements.

(i) *Agencies must establish and maintain an official office for the conduct of business with posted hours of operation. Branch offices must be within a one hundred (100) mile radius of the agency's main office's physical location. In order to ensure the health and safety of consumer, the main agency can service up to a one hundred (100) mile radius of the agency's physical location. The satellite office can also service up to one hundred (100) mile radius of its actual physical location.*

(ii) Agencies must meet all Americans with Disabilities Act (ADA) requirements.

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

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

(i) service delivery;

(ii) operational activi-

ties;

(iii) quality improvement action plan;

(iv) documentation of activities.

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

(a) communication skills;

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

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

(d) nutrition and meal preparation;

(e) housekeeping skills;

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

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

(h) basic infection control;

(i) home safety;

(7) a copy of a current and valid home health license, issued by the department of health, division of health improvement, licensing and certification (pursuant to 7.NMAC 28.2) may be submitted in lieu of requirements 3, 5 and 6 of this section; after certification, a copy of a current and valid home health license must be submitted annually along with proof of liability and workers' compensation insurance;

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

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

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

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

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

(1) being hired by the agency;

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

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

(4) being 18 years of age or older;

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

(6) successfully passing a nationwide criminal history screening, pursuant to 7.1.9 NMAC and in accord with NMSA 1978, Section 29-17-1 of the Caregivers Criminal History Screening Act, performed by an agency certified to conduct such checks; attendants are required to submit to a criminal history screening within the first 30 days of hire; an attendant may be conditionally (temporarily) hired by the consumer contingent upon the receipt of written notice of the nationwide criminal history screening; attendants who do not successfully pass a nationwide criminal history screening are not eligible for employment under the PCO program;

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

(8) successfully passing a written personal care attendant competency test with seventy-five percent (75%) or better within the first three (3) months of employment;

(9) completing 12 hours of training yearly; the attendant must obtain certification of CPR and first aid training within the first (3) three months of employment, and the attendant must maintain certification throughout the entire duration of providing PCO services; additional training will be based on the consumer's needs as listed in the PCSP; attendants are not required to be reimbursed for training time;

(10) being placed on DOH's PCO attendant registry and remaining in good standing with DOH on the PCO attendant registry; and

(11) providing the agency with a current tuberculosis (TB) skin test or chest x-ray upon initial employment with the agency per the current standards of the department of health; the results of the TB test must be documented in the attendant's personnel file; if the results are positive for TB, the individual cannot be hired as an attendant, and must seek treatment; after treatment and the individual has been given medical clearance, the individual may be employed by the agency; there must be documentation from a medical professional of treatment, and the agency must place a copy of the treatment documentation in the attendant's personnel file.

[8.315.4.11 NMAC - Rp 8 NMAC 4.MAD.738.2, 7/1/04]

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

A. be on a full benefit medicaid category and not be receiving medicaid home and community-based waiver services (HCBS), medicaid nursing facility (NF), intermediate care facility/mentally retarded (ICF/MR), PACE, CYFD attendant care program, or medicaid hospice services at the time PCO services are furnished; an individual residing in a NF or ICF/MR or receiving community-based services is eligible to apply for PCO services; all individuals must meet the financial/medical eligibility requirements under the PCO program to receive PCO services; the third-party assessor, MAD, or its designee must conduct an assessment or evaluation to determine if the transfer is appropriate and if the PCO program would be able to meet the needs of that individual;

B. be age twenty one (21) or older; be determined to have meet the level of care required in a nursing facility (high or low NF) by the third-party assessor or MAD's designee;

C. have an approved PCSP, developed by the consumer or personal representative, in conjunction with the third-party assessor or MAD's designee; and

D. comply with all medicaid policies and procedures.

[8.315.4.12 NMAC - Rp 8 NMAC 4.MAD.738.3, 7/1/04]

8.315.4.13 COVERAGE CRITERIA: Services under the personal care option program are defined as those tasks necessary a consumer's physical, social or cognitive functional ability. The goal of personal care is to avoid institutionalization, maintain or increase the consumer's functional level, and maintain or increase the consumer's independence. The personal care option program does not provide services 24 hours per day. Services are covered under the following criteria:

A. PCO services are usually furnished in the consumer's place of res-

idence. Services may be furnished outside the home, when appropriate and necessary and when not available through other existing benefits and programs, such as hospice and home health.

B. PCO services are not furnished to an individual who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, mental health facility, correctional facility, or other institutional settings. [8.315.4.13 NMAC - Rp 8 NMAC 4.MAD.738.7, 7/1/04]

8.315.4.14 COVERED SERVICES: Services covered under the PCO program are the following:

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

B. **Meal preparation and assistance:** at the direction of the consumer or his/her personal representative, prepare meal(s) for the consumer or assist the consumer pursuant to the PCSP. This does not include assistance with eating. Services requiring assistance with eating are covered under eating in Subsection G of 8.315.4.14 NMAC below.

C. **Support services:** Provide additional assistance to the consumer in order to promote his/her independence and enhance his/her ability to live in the community and remain in a clean and safe environment. These services include, but are not limited to:

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

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

(3) translating/interpreting through persons qualified to provide such services.

D. **Hygiene/grooming**: The PCSP may include the following tasks to be performed by the attendant. These services include but are not limited to:

(1) bathing;

(2) dressing;

(3) grooming;

(4) oral care with intact swallowing reflex;

(5) nail care;

(6) perineal care;

(7) toileting;

E. **Minor maintenance of assistive device(s):** Battery replacement and minor, routine wheelchair and durable medical equipment (DME) maintenance.

F. **Mobility assistance**: Assistance may include, but is not limited to:

(1) ambulation;

(2) transferring;

(3) toileting;

G. **Eating**: The attendant shall assist the consumer as determined by the PCSP. This does not include preparation of food/meals. Services requiring preparation of food/meals is covered under meal preparation and assistance in Subsection B of 8.315.4.14 NMAC. If the consumer has special needs in this area, the attendant is required to receive specific training to meet that need.

H. **Assisting with self-administered medication:** This service is limited to p*rompting and reminding only*. A consumer who needs assistance with taking self-administered medication as a reasonable accommodation under the Americans with Disabilities Act (ADA) due to a disability may receive assistance as per the PCSP. Examples of assistance include, but are not limited to, the following:

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

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

(3) helping a consumer with placement of oxygen tubes.

I. **Skin care:** The consumer must have a documented skin disorder. If documented by a physician, physician assistant, nurse practitioner or clinical nurse specialist, the attendant can perform skin care. Such assistance excludes wound care or application of prescription medications unless such assistance would be a reasonable accommodation under the ADA.

J. **Cognitive assistance:** Cognitive assistance is intended to keep the consumer on task, and increase or maintain the consumer's safety, independence, and quality of life. This service is primarily for a consumer with a traumatic brain injury, alzheimer's disease, a mental illness, dementia, or a consumer who has suffered a stroke;

K. **Household services:** The attendant will assist the consumer in performing household activities as needed. Such activities are limited to the maintenance of the consumer's personal living area (i.e., kitchen, living room, bedroom, and bathroom). These activities are considered necessary to maintain a clean and safe environment and to support the consumer living in his/her home. Examples of household services include:

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

(2) dusting the consumer's furniture;

(3) changing the consumer's linens;

(4) washing the consumer's laundry;

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

(6) cleaning the consumer's kitchen and dining area (i.e., washing the consumer's dishes, putting the consumer's dishes away; cleaning counter tops, cleaning the area where the consumer eats, etc.). [8.315.4.14 NMAC - Rp 8 NMAC 4.MAD.738.8, 7/1/04]

8.315.4.15 NON-COVERED SERVICES: The following services are not covered under the New Mexico medicaid personal care program:

A. any task that must be provided by a person with professional or technical training as specified by state and federal law;

B. services not approved in the consumer's approved PCSP; and

C. childcare or personal care for other household members. [8.315.4.15 NMAC - Rp 8 NMAC 4.MAD.738.9, 7/1/04]

8.315.4.16 THIRD-PARTY ASSESSOR (TPA): The TPA or MAD's designee is responsible for making level of care (LOC) determinations based on criteria developed by MAD or its designee (nursing facilities MAD 731); developing personal care service plans (PCSP), issuing prior approvals, and making utilization reviews

for all PCO consumers. The TPA or MAD's designee will explain, in detail, the two service delivery models, consumer-directed and consumer-delegated, annually; and is also required to provide the consumer with informational materials that explain both models and the PCO program in general. The TPA is not authorized to contract with any medicaid approved PCO agency to carry out TPA responsibilities. The TPA's responsibilities are as described below.

A. **Level of care (LOC):** To be eligible for PCO services, a consumer must meet the level of care required in a nursing facility, the medical eligibility criteria entails two distinct levels of care: a high nursing facility (HNF) or low nursing facility (LNF), (8.312.2 NMAC, *Nursing Facilities* [MAD 731]). A level of care packet is developed and approved by the TPA or MAD's designee.

(1) The packet must include:

(a) a current (within the last 12 months) MAD 075 signed by a physician, physician assistant, nurse practitioner or, clinical nurse specialist;

(b) any other information or medical justification documenting the consumer's functions abilities.

(2) The TPA or MAD's designee will use the LOC packet to:

(a) make all LOC determinations for all consumers requesting services under the personal care option program;

(b) approve the consumers LOC for a minimum of one year (12 consecutive months); and

(c) contact consumer within a minimum of ninety (90) days, prior to the expiration of the approved LOC, to being LOC determination process for PCO services, to ensure the consumer does not experience a break in PCO services.

(3) An agency that does not agree with the LOC determination made by the third-party assessor or MAD's designee may:

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

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

(4) A consumer that does not agree with the LOC determination made by the TPA or MAD's designee may request a fair hearing pursuant to 8.352.2 NMAC, *Recipient Hearings*.

(5) Agencies that have identified a consumer with a declining health condition or whose needs have changed and believe the consumer is in need of more services should refer the consumer to the TPA or MAD's designee for an additional assessment.

(6) Agencies who are providing PCO services to a consumer who becomes eligible for and would like to be placed onto the HCBS must submit a new LOC packet to MAD's utilization review contactor (UR) as outlined in UR policy for HCBS waivers.

B. **Personal care service plan (PCSP):** The PCSP is developed and personal care services are allocated, in conjunction with the in-home assessment and the current medical assessment form (MAD 075) for all consumers requesting services or continued services under the PCO program.

(1) The TPA or MAD's designee will:

(a) conduct an in-home assessment in the consumer's home;

(b) explain both service delivery models, consumer-directed and consumer-delegated to the consumer and/or his/her personal representative and provide the consumer and/or his/her personal representative with informational material, allowing the consumer to make the best educated decision possible regarding which model he/she will elect;

(c) determine and allocate personal care services using the LOC packet and the in-home assessment for the duration of one year (12 consecutive months);

(d) develop a PCSP in-conjunction with the consumer or his/her personal representative; participation in the development of a PCSP is not separately reimbursable for consumers or his/her personal representatives; the TPA or MAD's designee must ensure the consumer has participated in the development of the plan and that the PCSP is reviewed and signed by the consumer and/or the consumer's personal representative; a signature on the PCSP indicates that the consumer an/or personal representative agrees with the allocation of hours made by the TPA or MAD's designee and understands what services will be provided on a weekly basis and for the duration of one year; if a consumer is unable to sign the PCSP and the consumer does not have a personal representative, a thumbprint or personal mark (i.e., an "X") will suffice; if signed by a personal representative, the TPA or MAD's designee and the agency must have documentation in the consumer's file verifying the individual is the consumer's personal representative; the PCSP must include the following:

(i) description of the functional level of the consumer as evidenced by the primary care physician's clinical evaluation, including mental status, intellectual functioning and other supporting documentation;

(ii) statement of the nature of the specific limitations and the specific needs of the consumer for personal care services;

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

(iv) a description of intermediate and long range service goals, which includes the scope and duration of services, how goals will be attained and the projected timetable for their attainment.

(v) a statement describing the most integrated setting necessary to achieve the goals identified in the plan; and

(vi) a prior authorization (PA) number issued to the agency of the consumer's choice, for on-going billing purposes; a HCPC code must be tied to the PA based on the consumer's elected model of service delivery.

(e) approve PCO services for the duration of one year (12 consecutive months);

(f) provide the consumer with a copy of their approved PCSP; and

(g) contact consumer within a minimum of ninety (90) days, prior to the expiration of the approved PCSP, to being the re-assessment process for PCO services, to ensure the consumer does not experience a break in PCO services.

(2) Personal care agencies must:

(a) obtain an approved PCSP from the consumer;

(b) refer consumers to the TPA or MAD's designee who do not utilize services or the full amount of allocated services on the PCSP for 90 consecutive days. Documentation must be in the consumer's file demonstrating that a consumer has not utilized the full amount of hours allocated on the PCSP; and

(c) submit a personal care transfer/closure form (MAD 062) to the TPA or MAD's designee to close out a consumer's personal care services who has passed away.

[8.315.4.16 NMAC - Rp 8 NMAC 4.MAD.738.11 & 12, 7/1/04]

8.315.4.17 PRIOR APPROVAL AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for necessity and program compliance. Reviews by MAD or its designee and/or the TPA may be performed before services are furnished, after services are furnished, before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Approval And Utilization Review*.

Once enrolled, personal care providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. The agency must obtain an approved PCSP with a prior authorization number from the consumer, issued by the TPA or MAD's designee to ensure the consumer has been approved to receive personal care services;

B. PCO services must be included in the consumer's PCSP and must be approved by the TPA. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process. Agencies/consumers may be reviewed/audited by MAD, UR or MAD's designee at anytime to determine that need, delivery of service and quality of care are being met;

C. Prior approval of services does not guarantee that individuals are eligible for medicaid. Personal care agencies must verify that individuals are eligible for medicaid at the time services are furnished; and

D. An agency that does not agree with prior approval denials or other review decisions made by the TPA or MAD's designee may:

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

(b) is responsible for submitting the additional information and medical justification to the third-party assessor or MAD's designee and adhering to the timelines as out lined in medicaid oversight policies, 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions*[MAD-953].

E. A consumer who does not agree with prior approval denials or other review decisions made by the TPA or MAD's designee may request a fair hearing pursuant to 8.352.2 NMAC, *Recipient Hearings*.

[8.315.4.17 NMAC - Rp 8 NMAC 4.MAD.738.13, 7/1/04]

8.315.4.18 TRANSFER PROCESS: A consumer wishing to transfer services to another medicaid approved personal care agency may do so, for any reason, once within a plan year or when moving to another county without prior approval from MAD or its designee. All other transfers within the plan year may be requested by the consumer, but must be approved by MAD or its designee prior to the agency providing PCO services to the consumer. Transfers may only be initiated by the consumer and may not be requested by the attendant as a result of an employment issue. The consumer must give the reason for the requested transfer. A consumer requesting more than one transfer which is not related to moving to another county within a plan year will be sent to MAD or its designee by the TPA for processing.

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

(1) the consumer is requesting more hours;

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

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

(4) the consumer wants their legal guardian, spouse or attorney-in-fact to be their attendant who has previously been denied by MAD or its designee;

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

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

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

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

B. MAD or its designee will notify the consumer, the TPA and both the originating agency and the receiving agency of its decision. MAD or its designee has 15 working days after receiving the request from the TPA, to make a decision.

C. A consumer who does not agree with MAD or its designee's decision may request a fair hearing pursuant to 8.352.2 NMAC, *Recipient Hearings*. The originating agency is responsible for the continuance of PCO services throughout the fair hearing process.

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

(1) The consumer must inform both the agency he/she is currently receiving services from (originating agency) and the agency he/she would like to transfer to (receiving agency) about the transfer request.

(2) The receiving agency must contact the originating agency to discuss and agree on a transfer date in which the receiving agency will begin services and the originating agency will end services. Agencies should factor in, at a minimum, 10 workings days for the TPA to process the paperwork. Originating agencies are not responsible for submitting paperwork to the TPA or MAD's designee to close services when transferring a consumer to another agency.

(3) The receiving agency is responsible for completing the personal care transfer/closure form (MAD 062) and ensuring the consumer/personal representative has signed and dated the form.

(4) The receiving agency should mail the signed MAD 062 to the originating agency for signature. All three original signatures must be present for the TPA or MAD's designee to process the transfer.

(5) The originating agency must sign and mail the MAD 062, along with a copy of the consumers current PCSP (MAD 058), to the receiving agency within 48 hours of receiving the form. If the originating agency is disputing the transfer request for any reason, the agency should mark "disputing transfer" on the agency signature line and mail the MAD 062 to the receiving agency.

(6) The receiving agency must mail the MAD 062 to the TPA or MAD's designee for processing;

(7) The TPA or MAD's designee will issue a new prior authorization number to the receiving agency with new dates of service and units remaining for the remainder of the PCSP year. The TPA or MAD's designee will notify the consumer, by giving the consumer a revised PCSP to give to the receiving agency.

(8) The consumer is responsible for providing the receiving agency with the revised PCSP.

(9) The TPA or MAD's designee is responsible for tracking the number of transfer requests submitted by a consumer. If the TPA or MAD's designee determines that the consumer has exceeded the allowable number of transfers, or has received a transfer request marked "disputing transfer" the TPA or MAD's designee will mail the transfer request to MAD or its designee for approval or denial.

[8.315.4.18 NMAC - N, 7/1/04]

8.315.4.19 DISCHARGE PROCESS: The agency may discharge a consumer for a justifiable reason by means of a thirteen (13)-day written notice to the consumer and MAD or its designee. The notice must include the consumer's right to a request a fair hearing and must include the justifiable reason for the ageny's decision to discharge.

A. A justifiable reason for discharge may include:

(1) staffing problems (i.e., excessive request for change in attendants (three (3) or more in a 30-day period);

(2) a consumer who demonstrates a pattern of verbal/physical abuse of attendants or agency personnel, (i.e., use of vulgar/explicit language, verbal or physical sexual harassment, excessive use of force, verbal or physical intimidating threats); the agency or attendant must have documenta-

tion demonstrating the pattern of abuse; the agency may also discharge a consumer if the life of an attendant or agency's staff member is believed to be in immediate danger;

(3) a consumer and/or family member who demonstrates a pattern of uncooperative behavior (i.e., not complying with agency or medicaid policy; not allowing the agency to enter the home to provide services; continued requests to provide services not approved on the PCSP); the agency or attendant must have documentation demonstrating a pattern of uncooperative behavior;

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

(5) fraudulent submission of timesheets.

B. The agency must provide the consumer with a current list of medicaid-approved personal care agencies that service the county in which the consumer resides. The agency must assist the consumer in the transfer process and must continue services throughout the transfer process. If the consumer does not elect another agency, in the 13-day time frame, the current agency must continue services until MAD or its designee can arrange for the consumer's services to continue through another agency. The agency may not ask the TPA or MAD's designee to close the consumer's PCO services.

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

[8.315.4.19 NMAC - N, 7/1/04]

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

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

B. Reimbursement for personal care services is made at the lesser of the following:

(1) the provider's billed charge;

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

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

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

[8.315.4.20 NMAC - Rp 8 NMAC 4.MAD.738.14, 7/1/04]

8.315.4.21 OTHER:

A. An attendant may not act as the consumer's personal representative, in matters regarding medical treatment, financial or budgetary decision making, unless the attendant is the consumer's legal guardian, agent under a power of attorney, conservator, or representative payee and has received authorization to be the consumer's attendant pursuant to Paragraph (7) of Subsection A of 8.315.4.10 NMAC, Paragraph (10) of Subsection B of 8.315.4.10 NMAC, Paragraph (5) of Subsection D of 8.315.4.10 NMAC, Paragraph (20) of Subsection A of 8.315.4.11 NMAC, and Paragraph (5) of Subsection C of 8.315.4.11 NMAC. If the agency questions whether the consumer is able to direct his/her own care, an agency must make a referral to an appropriate social service or legal agency(s) for assistance.

B. A consumer who does not comply with the requirements for receiving personal care services may be denied such a service or have those services suspended. A consumer has the right to appeal this decision as outlined in the medicaid oversight policy, 8.352.2 NMAC, *Recipient Hearings.*

C. An agency wishing to advertise or conduct any type of community outreach for the PCO program must first get prior approval from MAD or its designee before conducting any such activity. An agency conducting any such activity without prior approval from MAD or its designee may be subject to a civil monetary penalty and/or have its medicaid provider participation agreement (MAD 312) terminated for conducting such activity without prior approval.

D. An agency may not deceive or misrepresent information to a potential personal care consumer. An agency conducting any such activity may be subject to a civil monetary penalty and/or termination of its provider participation agreement (MAD 312). This includes:

(1) contacting consumer who are receiving services through another medicaid program, including personal care;

(2) door-to-door solicitation of potential consumers;

(3) making false promises;

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

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

[8.315.4.21 NMAC - Rp 8 NMAC 4.MAD.738.15, 7/1/04]

HISTORY OF 8.315.4 NMAC:

History of Repealed Material:
8 NMAC 4.MAD.738, Personal Care Services - Repealed 7/1/2004.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.200.400 NMAC, Section 14 which will be effective on July 1, 2004. The Medical Assistance Division repealed the section since this provision has been deleted.

8.200.400.14 [~~12-MONTH CONTINUOUS ELIGIBILITY FOR CHILDREN:~~ ~~Children eligible for Medicaid will remain eligible for a period of twelve (12) months, regardless of changes in income. This provision applies even if the family income exceeds the applicable federal income poverty guidelines. The 12 month continuance starts with the month of approval or redetermination, and is separate from any months of presumptive or retroactive eligibility.~~] [Reserved]

[8.200.400.14 NMAC - Rn, 8.200.400.13 NMAC, 7-1-02; - Repealed, 7-1-04]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.200.510 NMAC, Section 12, which will be effective on July 1, 2004. The Medical Assistance Division amended by changing the deduction amounts.

8.200.510.12 POST-ELIGIBILITY CALCULATION (MEDICAL CARE CREDIT): Apply applicable deductions in the order listed below when determining the medical care credit for an institutionalized spouse.

[continued on page 603]

DEDUCTION	AMOUNT
A. Personal needs allowance for institutionalized spouse	[~~$50~~] $52
B. Basic community spouse monthly income allowance standard (CSMIA)	[~~$1,515~~] $1,562
(CSMIA standard minus income of community spouse = deduction	
C. * Excess shelter allowance for allowable expenses for community spouse	[~~$804~~] $757
D. ** Extra maintenance allowance	
E. Dependent family member 1/3 X (CSMIA - dependent member's income)	
F. Non-covered medical expenses	
G. * The allowable shelter expenses of the community spouse must exceed [~~$455~~] $469 per month for any deduction to apply.	
H. ** To be deducted, the extra maintenance allowance for the community spouse must be ordered by a court of jurisdiction or a state administrative hearing officer.	
I. **MAXIMUM TOTAL:** The maximum total of the community spouse monthly income allowance and excess shelter deduction is $2,319.	

[1-1-95, 7-1-95, 3-30-96, 8-31-96, 4-1-97, 6-30-97, 4-30-98, 6-30-98, 1-1-99, 7-1-99, 7-1-00; 8.200.510.12 NMAC - Rn, 8 NMAC 4.MAD.510.2 & A, 1-1-01, 7-1-01; A, 1-1-02; A, 7-1-02; A, 1-1-03; A, 7-1-03; A, 1-1-04; A, 7-1-04]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.202.600 NMAC, Sections 11 and 12, which will be effective on July 1, 2004. The Medical Assistance Division amended Section 11 by changing the redetermination period. Section 12 was amended to correction punctuation and update form numbers and names.

8.202.600.11 [~~CONTINUOUS~~] PERIODIC REDETERMINATIONS OF ELIGIBILITY: [~~Eligibility will continue for the twelve-month certification period, regardless of changes in income, as long as the family retains New Mexico residency and continues to have a dependent child residing in the household. Twelve-month continuous eligibility shall not be affected by the disposition of any other benefit(s) such as TANF, Food Stamps, etc.~~] A redetermination of eligibility is made every six (6) months. All changes that may affect eligibility must be reported within ten (10) days of the date of the change. Changes in eligibility status will be effective the first day of the following month.

[8.202.600.11 NMAC - N, 10-1-01; A, 7-1-04]

8.202.600.12 RETROACTIVE BENEFIT COVERAGE: Up to three months of retroactive medicaid coverage can be furnished to applicants/recipients who have received medicaid covered services during the retroactive period and who would have met applicable eligibility criteria had they applied during the three month period prior to the month of application. [42 CFR 435.914].

A. **Application for retroactive benefit coverage:** Application for retroactive medicaid can be made by checking [~~yes to the question Does anyone in your household have unpaid medical expenses in the last three (3) months? on the Application for Assistance (ISD-100-S) form or by checking yes to the question Does anyone have any unpaid medical bills from the past three months? on the Application for Medical Assistance for Children and Pregnant women (MAD023) form.~~] "yes" to the question "Does anyone have unpaid medical bills from the last three (3) months?" on the application for assistance (ISD 100) form or by checking "yes" to the question "Has anyone in the household received medical services within the last three (3) months which have not been paid?" on the medicaid application for women, children and families (MAD023) form. Applications for retroactive medicaid benefits must be made by 180 days from the date of application for assistance. Medicaid-covered services which were furnished more than two (2) years prior to application are not covered.

B. **Approval requirements:** To establish retroactive eligibility, the ISS must verify that all conditions of eligibility were met for each of the three (3) retroactive months and that the applicant received medicaid-covered services. Each month must be approved and denied on its own merits. Retroactive eligibility can be approved on either the ISD2 system or on the retroactive medicaid eligibility authorization (ISD 333) form.

C. **Notice:**

(1) **Notice to applicant:** The applicant must be informed if any of the retroactive months are denied.

(2) **Recipient responsibility to notify provider:** After the retroactive eligibility has been established, the ISS must notify the recipient that he/she is responsible for informing all providers with outstanding bills of the retroactive eligibility determination. If the recipient does not inform all providers and furnish verification of eligibility which can be used for billing and the provider consequently does not submit the billing within 120 days from the date of approval of retroactive coverage, the recipient is responsible for the bill.

[4/1/98; 8.202.600.12 NMAC - Rn, 8 NMAC 4.JUL.625, 10-1-01; A, 7/1/04]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.4 NMAC, Sections 9, 10 and 11, which will be effective on July 1, 2004. The Medical Assistance Division amended the section in order to comply with the Health Insurance Portability and Accountability Act (HIPAA).

8.305.4.9 MANAGED CARE ELIGIBILITY: HSD determines eligibility for enrollment in the managed care program. All medicaid eligible clients are required to participate in the medicaid managed care program except for the following:

A. clients eligible for both medicaid and medicare (dual eligibles);

B. institutionalized clients, defined as those expected to reside in a nursing facility for long term care or permanent placement; this does not include clients placed in a nursing facility to receive subacute or skilled nursing care in lieu of continued acute care;

C. clients residing in intermediate care facilities for the mentally retarded;

D. clients participating in the health insurance premium payment (HIPP) program;

E. children and adolescents in out-of-state foster care or adoption placements;

F. Native Americans;

G. clients eligible for medicaid category [~~035~~] 029, family planning services only; and

H. women eligible for medicaid category 052, breast and cervical cancer program.

[8.305.4.9 NMAC - Rp 8 NMAC 4.MAD.606.3.1, 7-1-01; A, 7-1-02; A, 7-1-04]

8.305.4.10 SPECIAL SITUATIONS:

A. **Newborn enrollment:** The following provisions apply to newborns:

(1) Newborns are automatically eligible for a period of [~~one year~~] six months and are immediately enrolled with the mother's MCO if the mother is a member at the time of the child's birth, regardless of where the child is born (that is, in the hospital or at home).

(2) If the child's mother is not a member of the MCO at the time of the birth in a hospital or at home, the child is enrolled during the next applicable enrollment cycle. If such a child is hospitalized at the time of enrollment, the MCO is not responsible for the child's care until discharge.

B. **Hospitalized clients:** Clients who become eligible for medicaid while hospitalized in a general acute care, a rehabilitation or free-standing psychiatric hospital are immediately eligible for enrollment in Salud!. However, the MCO is not responsible for the member's inpatient benefits (excluding newborns born to a member mother, see [~~8.305.4.10.A~~] Subsection A of 8.305.4.10 NMAC above) until the member is discharged from the hospital or transferred to a different level of care. HSD shall pay, on a fee-for-service basis, those provider-submitted claims related to [~~a member who is hospitalized at the time of enrollment~~] the hospitalization until such time as the member is discharged from the hospital. Transition services, e.g., DME supplies for the home, shall be the financial responsibility of the MCO.

C. **Clients in treatment foster care placements:** If a child or [~~youth up to 21 years of age~~] adolescent was residing in a treatment foster care placement at the time managed care enrollment began [~~for their geographic region of residence, on July 1, 1997, October 1, 1997, March 1, 1998 or June 1, 1998 and he has had an uninterrupted stay in treatment foster care, he shall remain~~] in 1997, they shall be exempt from enrolling in an MCO until he or she is discharged from treatment foster care.

D. **Native Americans:** Upon identifying himself as Native American, a Native American shall be afforded the option of participating in managed care or being covered by medicaid fee-for-service. Upon determination of medicaid eligibility, a Native American may choose to participate in managed care by enrolling in an MCO. By not enrolling in an MCO, the Native American chooses not to participate in a managed care plan and shall be covered through medicaid fee-for-service. After enrolling in an MCO, a Native American may opt out during the first [~~85~~] 90 days of any 12-month enrollment period (disenrollment). Disenrollment is effective the following month. At the end of the lock-in period, a Native American may re-enroll in an MCO. A medicaid eligible Native American may opt-in at any time by enrolling with an MCO. If an opt-in request is made prior to the [~~25th~~] 20th of the month, the opt-in shall become effective the following month. If the opt-in request is made after the [~~25th~~] 20th of the month and before the first day of the next month, the opt-in shall be effective on the first day of the second full month following the request.

(1) In compliance with federal requirements and authorizations, HSD may mandate that a Native American shall be afforded the option of participating in managed care or being covered under the primary care case management program (PCCM). Upon determination of medicaid eligibility, a Native American may choose to participate in managed care by enrolling in an MCO for the entire benefit package. By not enrolling in an MCO, the Native American chooses not to participate in a managed care plan and shall be covered under the PCCM program.

(2) In compliance with federal law and authorizations, HSD may mandate that a Native American who is receiving services under the PCCM program must choose an MCO to provide the transportation and pharmacy benefit packages only.

E. **Clients receiving hospice services:** Clients who have elected to receive hospice services and are receiving hospice services at the time they are determined eligible for medicaid will be exempt from enrolling in managed care unless they revoke their hospice election.

F. **Clients placed in nursing facilities:** If a member is placed in a nursing facility for what is expected to be a long term or permanent placement, the MCO remains responsible for the member until the member is disenrolled by HSD.

G. **Clients in third trimester of pregnancy:** A woman in her third trimester of pregnancy at the time of enrollment, who has an established obstetrical provider may continue that relationship. [~~The medical assistance division Program Policy Manual Section 8.305.11.9.H. NMAC provides~~] Refer to Paragraph (4) of Subsection H of 8.305.11.9 NMAC for special payment requirements.

H. **Clients placed in institutional care facilities for the mentally retarded (ICF/MR):** If a member is placed in an ICF/MR for what is expected to be a long-term or permanent placement, the MCO remains responsible for the member until the member is disenrolled by HSD.

I. In compliance with federal law and requirements, HSD may mandate that a member eligible for medicaid and medicare (dual eligibles) shall be enrolled with an MCO to receive benefits from the medicaid benefit package that are not provided by medicare. This program will be implemented in compliance with federal law and requirements.

[8.305.4.10 NMAC - Rp 8 NMAC 4.MAD.606.3.2, 7-1-01; A, 7-1-04]

8.305.4.11 MANAGED CARE STATUS CHANGE: A change of medicaid eligibility for a member enrolled in an MCO may result in managed care disenrollment or change of enrollment status within the MCO.

A. **Effect of exclusion and exempt status on managed care status:** If the member's medicaid eligibility status changes so that he is no longer a mandatory MCO enrollee, the member shall be disenrolled from the MCO.

(1) **Enrollment process immediately initiated:** If a client's eligibility status changes requiring mandatory enrollment in managed care, the enrollment process shall be initiated.

(2) **Delay in automatic assignment to MCO process:**

[~~(a) The enrollment process is not initiated immediately when the client is exempt from managed care enrollment caused by dual medicare and medicaid eligibility. The enrollment process is delayed 60 days to ensure clients have lost exempt status.~~]

[~~(b)~~] (a) A client who has been exempt by residing in a nursing facility or intermediate care facility for the mentally retarded and is discharged to live at home, shall be eligible for enrollment in managed care upon discharge.

[~~(c)~~] (b) [~~A client is identified as a Native American and chooses to opt in to managed care through self enrollment with an MCO.~~] A Native American client may choose to opt in to managed care at any time.

B. **Change in eligibility without change in managed care status:** If a member's eligibility category changes and enrollment in an MCO is mandatory for the new eligibility category, the member's managed care status shall not change. Members remain enrolled in the current MCO unless another change occurs which invalidates enrollment with the current MCO.

[8.305.4.11 NMAC - Rp 8 NMAC

4.MAD.606.3.3, 7-1-01; A, 7-1-04]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.6 NMAC, Sections 9, 12, 13, 14, 15, and 17, which will be effective on July 1, 2004. The Medical Assistance Division amended the section in order to comply with the Health Insurance Portability and Accountability Act (HIPAA).

8.305.6.9 GENERAL NETWORK REQUIREMENTS: The MCO shall establish and maintain a comprehensive network of providers willing and capable of serving members enrolled with the MCO.

A. **Service coverage:** The MCO shall provide or arrange for the provision of services described in 8.305.7 NMAC, *Benefit Package*, in a timely manner. The MCO is solely responsible for the provision of covered services and must ensure that its network includes providers in sufficient numbers and required specialists to make all services included in the package available and in accordance with access standards.

B. **Comprehensive network:** The MCO shall contract with the full array of providers necessary to deliver a level of care at least equal to, or better than, community norms. The MCO shall contract with a number of providers sufficient to maintain equivalent or better access than that available under medicaid fee-for-service. [~~The MCO contracts with providers shall require that the provider be in compliance with the HIPAA regulations.~~] The MCO shall take into consideration the characteristics and health care needs of its individual medicaid populations. The MCO must contractually require that all network providers and subcontractors be in compliance with the Health Insurance Portability and Accountability Act. In establishing and maintaining the network of appropriate providers, the MCO shall consider the following:

(1) the numbers of network providers who are not accepting new medicaid members;

(2) the geographic location of providers and medicaid members, considering distance, travel time, the means of transportation ordinarily used by medicaid members; and

(3) whether the location provides physical access for medicaid members, including members with disabilities.

C. **Maintenance of provider network:** The MCO shall notify HSD within five working days of unexpected changes to the composition of its provider network that negatively affects members access or the MCO's ability to deliver services included in the benefit package in a timely manner. Anticipated material changes in an MCO provider network shall be reported to HSD in writing [~~when~~] within 30 days prior to the change, or as soon as the MCO knows of the anticipated change [~~or within 30 calendar days, whichever comes first~~]. A notice of significant change must contain:

(1) the nature of the change;

(2) how the change effects delivery of or access to covered services; and

(3) the MCO's plan for maintaining access and the quality of member care.

[~~(1)~~] D. **Required policies and procedures:** The MCO shall maintain policies and procedures on provider recruitment and termination of provider participation with the MCO. The recruitment policies and procedures shall describe how an MCO responds to a change in the network that affects access and its ability to deliver services in a timely manner. The MCO:

(1) must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;

(2) must not discriminate against providers with respect to participation, reimbursement, or indemnification for any provider acting within the scope of that provider's license or certification under applicable state law solely on the basis of the provider's license or certification;

(3) must not decline to include individual or groups of providers in its network without giving the affected providers written notice of the reason for its decision;

(4) shall not be required to contract with providers beyond the number necessary to meet the needs of its members;

(5) shall be allowed to use different reimbursement amounts for different specialties or for different practitioners within the same specialty;

(6) shall be allowed to establish measures that are designed to maintain quality of services and control costs and are consistent with its responsibility to members;

(7) may not employ or contract with providers excluded from participation in federal health care programs because of misconduct; and

(8) shall not be required to contract with providers who are ineligible to receive reimbursement under medicaid fee-for-service.

[~~(2)~~] E. **General information submitted to HSD:** The MCO shall maintain an accurate unduplicated list of contracted, subcontracted, pending and terminated PCPs, specialists, hospitals and other providers participating or affiliated with the MCO. The MCO shall submit the list to HSD on a regular basis, determined by HSD, and include a clear delineation of all additions and terminations that have occurred since the last submission.

[~~(3) **Information in notice of network changes:** A notice of significant network changes must be submitted to HSD and contain the following information:~~

~~(a) the nature of the change;~~

~~(b) how the change affects delivery of or access to covered services; and~~

~~(c) the MCO's plan for maintaining access and the quality of member care.~~]

[8.305.6.9 NMAC - Rp 8 NMAC 4.MAD.606.5.1, 7-1-01; A, 7-1-03; A, 7-1-04]

8.305.6.12 PRIMARY CARE PROVIDERS: The primary care provider (PCP) must be a participating MCO medical provider who has the responsibility for supervising, coordinating and providing primary health care to members, initiating referrals for specialist care and maintaining the continuity of the member's care. The MCO shall distribute information to the providers explaining the medicaid-specific policies and procedures outlining PCP responsibilities.

A. **Primary care responsibilities:** The MCO shall develop policies and procedures to ensure that the following primary care responsibilities are met by the PCP or in another manner:

(1) 24-hour, seven day a week access to care;

(2) coordination and continuity of care with providers who participate within the MCO network and with providers outside the MCO network according to MCO policy;

(3) maintenance of a current medical record for the member, including documentation of services provided to the member by the PCP and specialty or referral services;

(4) ensuring the provision of services under the EPSDT program based on the periodicity schedule for members under age 21;

(5) requiring PCPs contracted with the MCO to vaccinate members in their offices and not refer members elsewhere for immunizations; the MCO shall encourage its PCPs to participate in the vaccines for children program administered by [~~DOH~~] the department of health (DOH);

(6) ensuring the member receives appropriate prevention services for his age group; [~~and~~]

(7) [~~following MCO established procedures for coordination of services for members with providers participating in the MCO network and providers outside the~~

~~MCO network. The MCO procedures for coordination of services shall ensure that~~] ensuring that care is coordinated with other types of health and social program providers, including but not limited to behavioral health, including mental health and substance abuse, the women, infants and children program (WIC), [~~CYFD~~] children, youth, and families department (CYFD), adult and child protective services and juvenile justice division;

(8) [~~the MCO shall:~~

~~(a) develop and implement policies and procedures~~] governing how coordination with the PCP will occur with hospitals that require in-house staff to examine or treat members having outpatient or ambulatory surgical procedures performed; and

[~~(b)~~] (9) [~~develop and implement policies and procedures~~] governing how coordination with the PCP and hospitalists will occur when [~~a member~~] an individual with a special health care need is hospitalized.

B. **Types of primary care providers:** The MCO may designate the following providers as PCPs, as appropriate:

(1) medical doctors or doctors of osteopathic medicine with the following specialties: general practice, family practice, internal medicine, gerontology, obstetrics, gynecology and pediatrics;

(2) certified nurse practitioners, certified nurse midwives and physician assistants;

(3) specialists, on an individualized basis for members whose care is more appropriately managed by a specialist, such as members with infectious diseases, chronic illness or a disability;

(4) primary care teams consisting of residents and a supervising faculty physician for contracts with teaching facilities or teams that include certified mid-level practitioners who, at the member's request, may serve as the point of first contact; in both instances, the MCO shall organize its teams to ensure continuity of care to members and shall identify a "lead physician" within the team for each member; the "lead physician" shall be an attending physician (medical students, interns and residents cannot serve as the "lead physician"); or

(5) other providers who meet the MCO credentialing requirements as a PCP.

C. **Providers that shall not be excluded as PCPs:** MCOs shall not exclude providers as primary care providers based on the proportion of high-risk patients in their caseloads.

D. **Selection or assignment to a PCP:** The MCO shall maintain written policies and procedures governing the process of member selection of a PCP and requests for a change in PCP.

(1) **Initial enrollment:** At the time of enrollment into the MCO, the MCO shall ensure that each member may choose a PCP within a reasonable distance from the member's residence.

(a) The MCO shall assume responsibility for assisting members with PCP selection.

(b) The process whereby the MCO assigns members to PCPs shall include at least the following features:

(i) the MCO shall contact the member within five business days of enrollment and provide information on options for selecting a PCP;

(ii) the MCO must offer freedom of choice to members in making a selection;

(iii) a member shall choose a PCP or the MCO will assign a PCP within 15 calendar days of enrollment with the MCO; a member may select a PCP from the information provided by the MCO; a member may choose a PCP anytime during this selection period;

(iv) the MCO shall notify the member in writing of his PCP's name, location and office telephone number; and

(v) the MCO shall provide the member with an opportunity to select a different PCP if he is dissatisfied with the assigned PCP.

(2) **Subsequent change in PCP initiated by member:** Members may initiate a PCP change at any time, for any reason. The request for PCP change may be made in writing or by telephone. [~~The MCO shall process the change within 30 days.~~] If the change is requested by the 20th day of the month it will become effective the first day of the following month. If the request is made after the 20th day it will become effective the first day of the second month following the request. A PCP change may also be initiated on behalf of a member by the member's parents or legal guardians of a minor or incapacitated adult.

(3) **Subsequent change in PCP initiated by the MCO:** In instances where a PCP has been terminated, the MCO shall allow affected members to select another PCP or make an assignment within 15 calendar days of the termination effective date. The MCO shall notify the member in writing of the PCP's name, location and office telephone number. The MCO may initiate a PCP change for a member under certain circumstances such as:

(a) the member and MCO agree that assignment to a different PCP in the MCO is in the member's best interest, based on the member's medical condition;

(b) a member's PCP ceases to participate in the MCO's network;

(c) a member's behavior toward the PCP is such that it is not feasible to safely or prudently provide medical care and the PCP has made all reasonable efforts to accommodate the member; or

(d) a member has initiated legal action against the PCP.

(4) **Provider lock-in:** HSD shall allow MCOs to require that a member see a certain provider while ensuring reasonable access to quality services when identification of utilization of unnecessary services or a member's behavior is detrimental or indicates a need to provide case continuity. [~~Such a lock-in shall be prior approved by HSD on a case-by-case basis.~~] Prior to placing a member on provider lock-in, the MCO shall inform the member of the intent to lock-in, including the reasons for imposing the provider lock-in and that the restriction does not apply to emergency services furnished to the member. The MCO's grievance procedure shall be made available to a member disagreeing with the provider lock-in. [~~Continuation of provider lock-in shall be reviewed and documented by the MCO and approved by HSD at least every six months.~~] The member shall be removed from provider lock-in when the MCO has determined that the utilization problems or detrimental behavior have ceased and that recurrence of the problems [~~are~~] is judged to be improbable. HSD shall be notified of provider [~~lock in~~] lock-ins on a quarterly basis and informed of provider lock-in removals at the time they occur.

E. **MCO responsibility for PCP services:** The MCO shall be responsible for monitoring PCP actions to ensure compliance with MCO and HSD policies. The MCO shall communicate with and educate PCPs about special populations and their service needs. The MCO shall ensure that PCPs are successfully identifying and referring members to specialty providers as medically necessary.

[8.305.6.12 NMAC - Rp 8 NMAC 4.MAD.606.5.4, 7-1-01; A, 7-1-04]

8.305.6.13 SPECIALTY PROVIDERS:

A. The MCO shall contract with a sufficient number of specialists with the applicable range of expertise to ensure that the anticipated needs of MCO members will be met within the MCO network of providers. The MCO shall have a system to refer members to providers who are not affiliated with the MCO network if providers with the necessary qualifications or certifications to provide the required care do not participate in the MCO's network.

B. The MCO shall have written policies and procedures for coordination of care and the arrangement and documentation of all referrals. The MCO policies and procedures shall designate the

process used by the MCO to ensure that referrals for all medically necessary services are available to members. The MCO referral process shall be effective and efficient and not impede timely access to and receipt of services.

C. A woman in her third trimester of pregnancy at the time of enrollment, who has an established obstetrical provider, may maintain that relationship. [~~(Medical Assistance Division Program Policy Manual 8.305.11.9.H.(4) NMAC~~] (Refer to Paragraph (4) of Subsection H of 8.305.11.9 NMAC, *Reimbursement for Women in the Third Trimester of Pregnancy*.)

D. The MCO or a specialist may initiate a change of specialists when the member's/guardian's behavior toward the specialist is such that it has made all reasonable efforts to accommodate the member /guardian and address the member's problems, but those efforts have been unsuccessful.

[8.305.6.13 NMAC - Rp 8 NMAC 4.MAD.606.5.5, 7-1-01; A, 7-1-04]

8.305.6.14 ACCESS TO SERVICES: The MCO shall demonstrate that its network is sufficient to meet the health care needs of enrolled members. HSD initially assesses the sufficiency of this network throughout the contract period. The MCO shall notify HSD of any changes in the MCO network. Changes affecting member access to care shall be communicated to HSD and remedied by the MCO in an expeditious manner.

A. **Provider to member ratios:**

(1) **PCP to member ratios:** The MCO shall ensure the member caseload of any PCP in its network does not exceed 1,500 [~~Salud! enrollees~~] of its own Salud! members. Exceptions to this limit may be made with the consent of the MCO and HSD. Reasons for exceeding the limit may include continuation of established care, assignment of a family unit or availability of mid-level clinicians in the practice which expand the capacity of the PCP.

(2) **Specialist to member ratios:** HSD shall not establish specific specialist to member ratios. The MCO must ensure that members have adequate access to specialty services.

B. **Compliance with specified access standards:** The MCO shall comply with all access standards delineated under the terms of the medicaid managed care contract with respect to geographic location, scheduling time and waiting times.

C. **Requirements for MCO policies and procedures:** The MCO shall maintain written policies and procedures describing how members and providers receive instructions on access to services including prior authorization and referral requirements for various types of medical or surgical treatments, emergency room services, and behavioral health services. The policies and procedures shall be made available in an accessible format, upon request, to HSD, network providers and members.

[8.305.6.14 NMAC - Rp 8 NMAC 4.MAD.606.5.6, 7-1-01; A, 7-1-04]

8.305.6.15 PUBLICLY SUPPORTED PROVIDERS: The MCO shall demonstrate how it incorporates and utilizes certain publicly supported providers who [~~served~~] serve many of the special needs of medicaid members and are considered important in maintaining continuity of care.

A. **Federally qualified health centers (FQHCs):** The MCO shall contract with FQHCs to the extent that access is required by federal law and in accordance with the Section 1915(b) waiver granted by [~~HCFA~~] CMS to the state. The MCO shall contract with at least one FQHC specializing in health care for the homeless in Bernalillo county and one urban Indian FQHC. An MCO with a contracted FQHC, which has no capacity to accept new members does not satisfy this requirement. If an MCO cannot meet the standard for FQHC access during the medicaid managed care contract period, the MCO shall allow its members to seek care from nonparticipating FQHCs. If the MCO and the FQHC cannot reach agreement as to reimbursement for services, the MCO shall agree to pay medicaid fee-for-service rates for the service in question.

B. **University of New Mexico health sciences center:** The MCO shall contract with the university of New Mexico health sciences center (UNMHSC) for specialty services provided by Carrie Tingley hospital and the university of New Mexico hospital, including transplants, neonate, burn and trauma, level I trauma center and other specialized pediatric services, when UNMHSC is the sole provider in the state. If the MCO and UNMHSC cannot reach agreement as to reimbursement for services, the MCO shall agree to pay medicaid fee-for-service rates for the services in question.

C. **Local department of health offices:** The MCO shall contract with public health providers for services described below in Paragraph (2) of Subsection C of 8.305.6.15 NMAC and those defined by state law as public health services.

(1) **Children's medical services [~~(CMS)~~]:** The MCO shall contract with [~~CMS~~] children's medical services, which administers outreach clinics at sites throughout the state. The [~~CMS~~] children's medical service clinics offer pediatric subspecialty services in local communities, which include cleft palate, neurology, endocrine, asthma and pulmonary.

(2) **Specific requirements for local and district health offices:** The MCO must contract with local and district public health offices to provide the following services:

(a) family planning services;

(b) the MCO may require PCPs to participate in the vaccines for children (VFC) program administered by the department of health; and

(c) in addition, the MCO may contract with local and district health offices for other clinical preventive services not otherwise available in the community, such as prenatal care or perinatal case management.

(3) **Shared responsibility between MCO and public health offices:** The MCO shall coordinate with public health offices regarding the following services:

(a) screening, diagnosis, treatment, follow-up and contact investigations of sexually transmitted disease;

(b) HIV prevention counseling, testing and early intervention;

(c) screening, diagnosis and treatment of tuberculosis;

(d) disease outbreak prevention and management, including reporting according to state law requirements, responding to epidemiology requests for information and coordination with epidemiology investigations and studies;

(e) referral and coordination to ensure maximum participation in the supplemental food program for women, infants and children (WIC);

(f) health education services for individuals and families with a particular focus on injury prevention including, but not limited to, car seat use, domestic violence, substance use and lifestyle issues including tobacco use, exercise and nutrition;

(g) development and support for family support programs, such as home visiting programs for families of newborns and other at-risk families and parenting education;

(h) participating in and support for local health councils to create healthier and safer communities with a focus on coordination of efforts such as DWI councils, maternal and child health councils, tobacco coalitions, safety councils, safe kids and others; and

(i) vaccines for children program.

D. **School-based providers:** The MCO must make every

effort to include school-based health clinics as network providers or provide the same level of access in the school setting. [~~The MCO shall participate in the pilot project entitled "*Linking School-Based Health Centers with Salud!*" and the future possible expansion of the pilot project.~~]

E. **State-run institutions.** The MCO shall make every effort to use certain state-run institutions that provide highly specialized services and provide a "safety net" function for certain high-risk populations. These state-run institutions are Sequoyah adolescent treatment center and the CARE unit of the Las Vegas medical center, which are administered by the department of health (DOH), [~~and La Placita Community Residential Treatment Center,~~] and Carlsbad community residential treatment center, which [~~are~~] is administered by the children, youth and families department (CYFD).

F. **Indian health services (IHS) and tribal health centers:** The MCO shall allow members who are Native American to seek care from IHS, tribal or urban Indian program providers defined in the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.), whether or not the provider participates as part of the MCO's provider network. The MCO may not prevent members who are IHS beneficiaries from seeking care from IHS, tribal or urban Indian providers.

[8.305.6.15 NMAC - Rp 8 NMAC 4.MAD.606.5.7, 7-1-01; A, 7-1-04]

8.305.6.17 PROVIDER EDUCATION AND COMMUNICATION:

A. The MCO shall establish and maintain policies and procedures governing the development and distribution of education and informational materials regarding Salud! to its network providers. Policies and procedures shall:

[~~A.~~] (1) inform providers of the conditions of participation with the MCO regarding Salud!;

[~~B.~~] (2) inform providers of their responsibilities to the MCO and to Salud! medicaid members;

[~~C.~~] (3) inform providers of Salud!-specific policies and procedures, including information on primary and specialized medical care and related information and services specific to the needs of [~~Children~~] individuals with special health care needs [~~(CSHCN)~~] (ISHCN) and other special populations;

[~~D.~~] (4) [~~furnish providers with policies and procedures~~] inform providers regarding cultural competency and provide ongoing educational opportunities for providers and their staff on cultural competency;

[~~E.~~] (5) provide information on credentialing and recredentialing, prior authorization and referral processes and how to request and obtain a second opinion;

[~~F.~~] (6) [~~furnish providers with policies and procedures and~~] inform providers on how to access care coordination [~~of~~] services for physical, behavioral and social support [~~services, statewide, both internally for services which are covered by Salud! and externally to the MCO for non-covered services~~] needs, including covered benefits and services outside the benefit package;

[~~G.~~] (7) [~~furnish~~] inform providers [~~with policies and procedures~~] regarding the delivery of the federally mandated EPSDT services; and

[~~H.~~] (8) furnish providers with information on the MCO's internal provider grievance process by which providers can express their dissatisfaction with the plan's actions and file a complaint.

[~~I.~~] B. In addition to the above, the MCOs shall:

(1) conduct an annual provider satisfaction survey, the results of which will be incorporated into the MCO's quality improvement (QI) program; survey results will be forwarded to HSD;

[~~J.~~] (2) [~~The MCO shall~~] actively solicit input from its network providers in an effort to improve and resolve problem areas related to the Salud! program; the information provided will be incorporated into the MCO's QI program; and

[~~K.~~] (3.) [~~The MCO shall~~] submit an annual provider educational training schedule to HSD; the information shall include the scheduled trainings for the MCO's network providers, including behavioral health providers. The MCO shall be able to provide HSD evidence, when requested, of ongoing provider educational activities scheduled throughout the year and throughout the state; evidence of such activities may include: a provider education schedule of events held throughout the state; provider manuals distributed to contracted providers and updated at least quarterly; publications, such as brochures and newsletters; or media, such as films, videotaped presentations, seminars; and schedules of classroom instruction.

C. The MCO shall maintain and continue these activities with its network providers, including behavioral health, throughout the term of the MCO provider contractual relationship.

[8.305.6.17 NMAC - N, 7-1-01; A, 7-1-04]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.8 NMAC, Sections 9, and 11 through 19, which will be effective on July 1, 2004. The Medical Assistance Division amended the section in order to comply with the Health Insurance Portability and Accountability Act (HIPAA).

8.305.8.9 QUALITY MANAGEMENT: HSD recognizes that strong programs of quality improvement and assurance help ensure that better care is delivered in a cost-effective manner to the member. Under the terms of the medicaid managed care contracts, quality management programs are incorporated into health care delivery and administrative systems. [~~The MCO shall comply with the following standards.~~]

[8.305.8.9 NMAC - Rp 8 NMAC 4.MAD.606.7, 7-1-01; A, 7-1-04]

8.305.8.11 BROAD STANDARDS:

A. **NCQA requirement:** The MCO shall have and maintain national committee for quality assurance (NCQA) accreditation for its medicaid product line. If the MCO is not so accredited, it will actively pursue such accreditation.

(1) An MCO with NCQA accreditation shall provide HSD a copy of its current certificate of accreditation together with a copy of the survey report, scores for the medicaid product line using the standards categories and scores using the reporting categories. In addition, the MCO shall provide to HSD a copy of any annual NCQA review/revision of accreditation status for the medicaid product line.

(2) If the MCO is not accredited, it must provide a copy of the NCQA confirmation letter indicating the date for the site visit.

B. **HEDIS requirement:** The MCO shall submit a copy of its audited HEDIS (health plan employer data and information set) data submission tool to HSD at the same time it is submitted to NCQA. The results of the MCO's HEDIS ® Compliance Audit ™ must accompany its data submission tool.

C. **Mental health reporting requirement:** The MCO shall use the mental health statistics improvement project (MHSIP) as an annual reporting requirement for behavioral health services. The MCOs shall report the MHSIP data set and any additional HSD [~~specified~~] requested data which [~~is~~] are similar to that of MHSIP to HSD for [~~a given~~] each contract calendar year [~~within the first six (6) months of the next year~~]. The MCO shall submit to HSD the completed calculation of performance indicators in a written report.

D. **Collection of clinical data:** For indicators requiring clinical data as a data source, the MCO shall collect and

utilize a sample of clinical records sufficient to produce statistically valid results. The size of the sample shall support stratification of the population by a range of demographic and clinical factors pertinent to the special vulnerable populations served. These populations shall include, but are not limited to, ethnic minorities, homeless, pregnant women, gender and age.

E. **Behavioral health data:** Performance indicator data shall be collected and reported for any member receiving any behavioral health service provided by a licensed or certified behavioral health practitioner (including behavioral health case managers), regardless of setting or location as required by HSD. This includes behavioral health licensed professionals, practicing within the physical health plan. Only those services provided in the primary care setting directly by the PCP are excluded.

F. **Provision of emergency services:** The MCO shall ensure that acute general hospitals are reimbursed for emergency services, which they will provide because of federal mandate, such as the "anti-dumping" law in the Omnibus Reconciliation Act of 1989, P.L. (101-239) and 42 U.S.C. Section 1395dd. (1867 of the Social Security Act).

G. **Disease reporting:** The MCO shall encourage its providers to comply with the disease reporting required by the "New Mexico Regulations Governing the Control of Disease and Conditions of Public Health Significance, 1980".

[8.305.8.11 NMAC - Rp 8 NMAC 4.MAD.606.7.2, 7-1-01; A, 7-1-04]

8.305.8.12 STANDARDS FOR QUALITY MANAGEMENT AND IMPROVEMENT:

A. **Program structure:** The MCO's quality management and improvement (QI) structures and processes shall be planned, systematic, [~~and~~] clearly defined, and at least as stringent as federal requirements; [~~and~~] responsibilities shall be assigned to appropriate individuals. The QI program shall be approved by HSD annually.

(1) The QI program shall include: goals, objectives and structure that cover the plan's efforts to monitor and improve clinical care and service.

(2) The QI program shall be accountable to the governing body [~~which~~] that reviews and approves the QI program.

(3) The program description shall specify the roles, authority and responsibilities of a designated physician/psychiatrist in the QI program.

(4) A committee shall oversee and be involved in QI activities.

(5) The program description shall specify the role of the QI committee and subcommittees, including any committees dealing with oversight of delegated activities.

(6) The program description shall describe QI committee composition, including MCO providers, committee member selection policies, roles and responsibilities.

(7) The program description shall include: the QI committee functions, including policy recommendations; review/evaluation of quality improvement activities; institution of needed actions; follow-up of instituted actions; and contemporaneous documentation of committee decisions and actions.

(8) The program description shall address QI for all major demographic groups within the MCO, such as, infants, children, adolescents, adults and special population groups, including: specific racial and ethnic groups, pregnant members, developmentally disabled members and persons with behavioral health disorders or other chronic diseases.

(9) The program description shall address member satisfaction, including methods of collecting and evaluating information (including the consumer assessment of health plans survey (CAHPS) H survey), identifying opportunities for improvement, implementing and measuring effectiveness of intervention and informing providers of results.

(10) The description or work plan shall address the process by which the MCO adopts, reviews at least every two years, appropriately updates and disseminates evidence-based clinical practice guidelines for provision of services for acute and chronic conditions. [~~As part of the process,~~] The MCO shall involve its providers in this process.

(11) The program description or work plan shall address activities aimed at addressing culture-specific health beliefs and behaviors as well as risk conditions and [~~responding~~] shall respond to member and provider requests for culturally appropriate services. Culturally appropriate services may include: language and translation services, dietary practices, individual and family [~~interactional~~] interaction norms and the role of the family in compliance with long-term treatment. The MCO shall incorporate cultural competence into utilization management, quality improvement, and the planning for the course of treatment.

(12) The program description or work plan shall address activities to improve health status of members with chronic conditions, including identification of such members; implementation of services and programs to assist such members in managing their conditions, including behavioral health; and informing providers about the programs and services for members assigned to them.

(13) The program description or work plan shall address activities that ensure continuity and coordination of care, including general [~~medical~~] physical and behavioral health services, collection and analysis of data, and appropriate interventions to improve coordination and continuity of care.

(14) The program description or work plan shall include specific activities that facilitate continuity and coordination of physical and behavioral health care. The responsibility for these activities shall not be delegated.

(15) The program description shall include: objectives for the year; activities regarding quality of clinical care and service; timelines, responsible person, planned monitoring for both newly identified and previously identified issues; and planned, annual evaluation of the QI program.~~-~~

(16) The program description shall include means by which the MCO shall, upon request, communicate quality improvement results to its members and providers.

(17) The QI program personnel and information resources shall be adequate to meet program needs and devoted to and available for quality improvement activities.

(18) The annual written evaluation shall include a review of completed and continuing quality improvement activities that address quality of clinical care and quality of service; determination of any demonstrated improvements in quality of care and service; and evaluation of the overall effectiveness of the QI program based on evidence of meaningful improvements (See Subsection J of 8.305.8.12 NMAC, *Effectiveness of the QI Program*)

(19) For targeting QI activities to the provider and consumer surveys, the program description or work plan shall include specific activities related to findings identified in the annual consumer and provider surveys as areas that indicate targeted QI interventions and monitoring.

B. **Program operations:**

[~~(1)~~] The QI committee shall:

[~~(a)~~] (1) recommend QI policy review and evaluate the results of quality improvement activities, institute needed action and ensure follow-up, as appropriate;

[~~(b)~~] (2) have contemporaneous dated and signed minutes that reflect all QI committee decisions and actions;

[~~(c)~~] (3) ensure that the MCO's providers participate actively in the QI program;

[~~(d)~~] (4) ensure that the MCO

shall coordinate the QI program with performance monitoring activities throughout the organization, including but not limited to, utilization management, fraud and abuse detection, credentialing, monitoring and resolution of member [~~complaints~~] grievances and appeals, assessment of member satisfaction and medical records review;

[~~(e)~~] (5) ensure that there shall be linkage between the QI program and other management activities, such as network changes, benefits redesign, practice feedback to providers, member health education and member services, which will be documented in quarterly progress reports;

[~~(f)~~] (6) ensure that there shall be evidence that the results of QI activities performance improvement projects and reviews are used to improve quality; there will be evidence of communication of and use of the results of QI activities, performance improvement projects and reviews, with appropriate individual and institutional providers;

[~~(g)~~] (7) ensure that the MCO shall also coordinate the QI program with performance monitoring activities throughout the organization, including but not limited to, its compliance with all quality standards and other specifications in the contract for medicaid services[~~, and~~] , such as compliance with state standards;

[~~(h)~~] (8) ensure that the MCO shall ensure that the QI program is applied to the entire range of health services provided through the MCO by assuring that all major population groups, care settings and types of service are included in the scope of the review; a major population or prevalent group is one [~~which~~] that represents at least [~~10%~~] 5% of an MCO's enrollment; and

(9) ensure that stakeholders/members have an opportunity to provide input.

C. **Health services contracting:** Contracts with individual and institutional providers shall specify that contractors cooperate with the MCO's QI program. [~~Contracts with providers shall specifically require that:~~

~~(1) the provider cooperate with QI activities;~~

~~(2) the MCO, HSD, and its agent have access to medical records pertaining to medicaid members.~~]

D. **Continuous quality improvement/total quality management:** The MCO shall ensure that clinical and non-clinical aspects of the MCO quality management program shall be based on principles of continuous quality improvement/total quality management (CQI/TQM). Such an approach shall include at least the following:

(1) recognition that opportunities for improvement are unlimited;

(2) be data driven;

(3) use member and provider input; and

(4) require on-going measurement of clinical and non-clinical effectiveness and programmatic improvements.

E. **Member satisfaction:** The MCO shall implement methods aimed at member satisfaction with the active involvement and participation of members.

(1) The MCO, in accordance with NCQA guidelines, shall conduct as part of its HEDIS reporting requirements, an annual survey of member satisfaction (CAHPS H or latest version of adult and child instruments) with the MCO.

(2) The MCO shall evaluate member [~~complaints,~~] grievances and appeals for trends and specific problems, including behavioral health problems.

(3) The MCO shall use input from the consumers advisory board to identify opportunities for improvement in the quality of MCO performance.

(4) The MCO shall implement interventions to improve its performance.

(5) The MCO shall measure the effectiveness of the interventions.

(6) The MCO shall inform providers, [~~the state medicaid agency and its~~] HSD, and the MCO members of the results of member satisfaction activities.

(7) The MCO shall participate in the design of specific questions for the CAHPS adult and child surveys with HSD.

F. **Health management systems:**

(1) The MCO shall actively work to improve the health status of its members with chronic [~~medical conditions, including behavioral health.~~] physical and behavioral health conditions, utilizing best practices throughout the MCOs provider networks.

(a) The MCO shall identify members with chronic medical conditions and offer appropriate services and programs to assist in managing and improving their conditions.

(b) The MCO shall identify the number of adult severely disabled mentally ill (SDMI) and severely emotionally disturbed children (SED) and chronic substance abuse (CSA) members served.

(c) The MCO shall report the following adverse events involving SDMI, SED and CSA members to HSD on a monthly basis: suicides, other deaths, attempted suicides, involuntary hospitalizations, detentions for protective custody and detentions for alleged criminal activity. The MCOs shall utilize HSD's definitions for the identification of these categories of behavioral health members for standardization purposes.

(d) The MCO shall identify [~~Children~~] individuals with special health care needs who have or are at increased risk for a chronic physical and behavioral health condition.

(e) The MCO shall inform and educate its providers about using the health management programs for the members.

(f) The MCO shall participate with providers to reduce inappropriate use of psychopharmacological medications and adverse drug reactions.

(g) The MCO shall periodically update its providers on the procedures for referral.

(2) The MCO shall pursue continuity of care for members.

(a) The MCO shall report changes in its provider network.

(b) The MCO shall have a defined process to promote a high level of member compliance with follow-up appointments, consultations/referrals and diagnostic laboratory, diagnostic imaging and other testing.

(c) The MCO shall have a defined process to ensure prompt member notification by its providers of abnormal results of diagnostic laboratory, diagnostic imaging and other testing and this will be documented in the medical record.

(d) The MCO shall ensure that the processes for follow-up visits, consultations and referrals are consistent with high quality care and service and do not create a clinically significant impediment to timely medically necessary services. The determination of medical necessity shall be based on HSD's medical necessity definition and its application.

(e) The MCO shall ensure that all medically necessary referrals are arranged and coordinated by the referring provider.

(f) The MCO shall monitor continuity and coordination of care across practices and provider sites. In particular, the MCO shall coordinate, in accordance with applicable state and federal privacy laws, with other state agencies such as CYFD protective services and juvenile justice and school districts, through the care coordination process.

(g) The MCO shall assist with transitions between providers in order to avoid abrupt changes in treatment plan and caregiver for members currently being served.

(3) At the request of a member, the MCO shall provide information on options for converting coverage to a different insurance to members whose enrollment is terminated due to loss of medicaid eligibility and this shall be documented.

G. **Clinical practice guidelines:** The MCO shall disseminate recommended practice guidelines, practice parameters, consensus statements and specific criteria for the provision of acute and chronic physical and behavioral health care services.

(1) The MCO shall select the clinical issues to be addressed with clinical guidelines based on the needs of the medicaid populations.

(2) The clinical practice guidelines shall be based on reasonable medical evidence.

(3) The MCO shall involve providers from its network who are appropriate to the clinical issue in the development and adoption of clinical practice guidelines.

(4) The MCO shall develop a mechanism for reviewing the guidelines when clinically appropriate, but at least every two years, and updating them as appropriate.

(5) The MCO shall distribute the guidelines to the appropriate providers and to HSD, upon request.

(6) The MCO shall periodically measure practitioner performance against at least three guidelines and determine consistency of decision-making based on the clinical practices guidelines.

(7) Decision-making in utilization management, member education, interpretation of covered benefits and other areas shall be consistent with those guidelines.

H. **Quality assessment and performance improvement:** The MCO shall achieve required minimum performance levels, as established by HSD and by CMS, on certain quality measures. These required levels of performance [~~will~~] would address a broad spectrum of key aspects of enrollee care and services. These quality measures may change from year to year and may be used in part to determine the assignment algorithm. In addition, the MCO shall provide HSD with copies of all studies performed for NCQA.

(1) [~~Up to six quality improvement projects shall be identified by HSD in consultation with the MCO at the beginning of each contract year.~~] An agreed upon number of disease management/performance measures shall be identified by HSD, in consultation with the MCOs, at the beginning of each contract year. The MCO shall achieve minimum performance levels set by HSD for each performance [~~improvement project~~] measure. Examples of quality measures used in performance improvement projects may include: EPSDT screening rates, childhood immunization rates, ER visits or adherence to [~~complaint and~~] grievance resolution timeframes.

(2) The MCO shall measure its performance, using claims, encounter data and other predefined sources of information, [~~(for example, utilization management system and medical records,~~] and report its performance on each measure to HSD at a frequency determined by [~~MAD)~~] HSD.

[~~(3) The MCO shall achieve the minimum performance levels established by HSD specific to each measure.~~]

I. **Intervention and follow-up for clinical and service issues:** The MCO shall take action to improve quality by addressing opportunities for improving performance identified through clinical and service QI activities, as appropriate, and shall also assess the effectiveness of the interventions through systematic follow-up.

(1) The MCO shall implement interventions to improve practitioner and system performance as appropriate.

(2) The MCO shall implement appropriate corrective interventions when it identifies individual occurrences of poor quality.

(3) The MCO shall implement appropriate corrective interventions when it identifies underutilization or overutilization.

J. **Effectiveness of the QI program:** The MCO shall evaluate the overall effectiveness of its QI program and demonstrate improvements in the quality of clinical care and the quality of service to its members.

(1) The MCO shall perform an annual written evaluation of the QI program and provide a copy to HSD for CMS review. This evaluation shall include at least the following:

(a) a description of completed and ongoing QI activities;

(b) trending of measures to assess performance in quality of clinical care and quality of service;

(c) an analysis of whether there have been demonstrated improvements in the quality of clinical care and quality of service; and

(d) an evaluation of the overall effectiveness of the QI program.

(2) There shall be evidence that QI activities have contributed to meaningful improvement in the quality of clinical care and quality of service, including preventive behavioral health care, provided to members.

[8.305.8.12 NMAC - Rp 8 NMAC 4.MAD.606.7.2, 7-1-01; A, 7-1-04]

8.305.8.13 STANDARDS FOR UTILIZATION MANAGEMENT: The MCO's utilization management (UM) program shall assign responsibility to appropriate individuals in order to manage the use of limited resources; to maximize the effectiveness of care by evaluating clinical appropriateness; to authorize the type and volume of services through fair, consistent and culturally competent decision making; and to assure equitable access to care. The MCO UM program will be based on clinical criteria established and implemented consistently across the state by the MCO, which is congruent with HSD's medically necessary service definition, as defined in 8.305.1 NMAC.

A. **Program design:**

(1) A written description of the UM program shall outline the program structure and include a clear definition of authority and accountability for all activities [~~and~~] between the MCO and entities to which the MCO delegates UM activities.

(2) A designated physician and a behavioral health care physician shall have substantial involvement in the design and implementation of the UM program.

(3) The description shall include the scope of the program; the processes and information sources used to determine benefit coverage; clinical necessity, appropriateness and effectiveness; policies and procedures to evaluate care management, discharge criteria, site of services, levels of care, triage decisions and cultural competence of care delivery; processes to review, approve and deny services; processes to evaluate service outcomes; and a plan to improve outcomes, as needed. The above service definitions are to be no less than the amount, duration and scope for the same services furnished to members under fee-for-service medicaid as set forth in 42 CFR Section 440.230.

(4) The MCO shall ensure that the services are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. The MCO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the beneficiary's diagnosis, type of illness, or condition.

[~~(4)~~] (5) The UM program shall be evaluated and approved annually by senior management and the medical director or the QI committee.

B. **UM decision criteria:** To make utilization decisions, the MCO shall use written utilization review decision criteria that are based on reasonable medical evidence and that are applied in a fair, impartial and consistent manner to serve the best interests of members.

(1) UM decisions shall be based on reasonable and scientifically valid utilization review criteria that are objective and measurable insofar as practical.

(2) The criteria for determining medical necessity shall be academically defensible; based on national standards of practice when such standards are available; and acceptable to the MCO's medical director, peer consultants and relevant local providers. The MCO shall specify what constitutes medically necessary services in a manner that is no more restrictive than that used by HSD as indicated in state statutes and regulations. According to this

definition, the MCO must be responsible for covered services related to the following:

(a) the prevention, diagnosis, and treatment of health impairments; and

(b) the ability to attain, maintain, or regain functional capacity.

(3) Criteria for determination of medical appropriateness shall be clearly documented.

(4) There shall be evidence that the MCO has reviewed the criteria at specified intervals and that the criteria have been updated, as necessary.

(5) The MCO shall provide the criteria to its providers upon request.

(6) At least annually, the MCO shall evaluate the consistency with which the health care professionals involved in the utilization review apply the criteria in decision-making.

C. **Authorization of services:** For the processing of requests for initial and continuing authorization of services, the MCO must:

(1) require that its subcontractors have in place written policies and procedures;

(2) have in effect a mechanism to ensure consistent application of review criteria for authorization decisions;

(3) consult with requesting providers when appropriate.

[~~C.~~] D. **Use of qualified professionals:** Qualified health professionals shall assess the clinical information used to support UM decisions.

(1) Appropriately licensed and experienced health care practitioners whose education, training, experience and expertise are commensurate with the UM reviews conducted shall supervise review decisions.

(2) Denials based on medical necessity shall be made by a designated physician for the UM program. The reason for the denial shall be cited.

(3) For a health service determined to be medically necessary but for which the level of care (setting) is determined to be inappropriate, the MCO shall approve the appropriate level of care as well as deny that which was determined to be inappropriate.

(4) The reasons for review decisions (approve/deny) shall be clearly documented and communicated to the requesting practitioner responsible for justifying the medical necessity.

[~~D.~~] E. **Timeliness of decisions:** The MCO shall make utilization decisions in a timely manner that accommodates the clinical urgency of the situation and shall minimize disruption in the provision and continuity of health care services. The following time frames are required, based on NCQA standards, and shall not be affected by "pend" decisions.

(1) For [~~authorization of nonurgent~~] precertification of non-urgent (routine) care, the MCO shall make decisions within [~~two working days of obtaining the necessary information,~~] fourteen (14) days from receipt of request for service with a possible extension of up to fourteen (14) additional calendar days if the enrollee or the provider requests the extension or the MCO justifies to the HSD upon request a need for additional information and how the extension is in the enrollee's interest.

(2) For authorization of [~~nonurgent~~] non-urgent care, the MCO shall notify a provider of the decision within one working day of making the decision.

(3) For authorization of [~~nonurgent~~] non-urgent care that results in a denial, the MCO shall give the member and provider written or electronic confirmation of the decision within two working days of making the decision.

(4) For [~~authorization~~] precertification of urgent care, the MCO shall make a decision and notify the provider of the decision within [~~one day~~] seventy-two hours of receipt of request.

(5) For authorization of urgent care that results in a denial, the MCO shall notify both the member and provider that an expedited appeal has already occurred.

(6) For authorization of urgent care that results in a denial, the MCO shall give the member and provider written or electronic confirmation of the decision within two working days of making the decision.

(7) For concurrent review of services, the MCO shall make decisions for:

(a) inpatient care within one working day of obtaining the necessary information and

(b) ongoing ambulatory care within 10 working days of obtaining the necessary information.

(8) For concurrent review, the MCO shall notify providers of decisions within one working day of making the decision.

(9) For concurrent review decisions that result in a denial, the MCO shall give the member and provider written or electronic confirmation within one working day of the original notification.

(10) For concurrent review decisions that result in a denial, the MCO shall notify the member and provider how to initiate an expedited appeal at the time of notification of the denial.

~~[(11) The MCO shall establish procedures for registering and responding to expedited appeals.~~

~~(12) An expedited appeal may be initiated by the member, legal guardian or by a practitioner acting on behalf of the member.~~

~~(13) The MCO shall make the expedited appeal decision and notify the member, legal guardian and practitioner as expeditiously as the medical condition requires, but not later than three calendar days after the review commences.~~]

(11) For authorization decisions of non-urgent or urgent care, a 14-calendar-day extension may be requested by the member or provider. A 14-day extension may also be requested by the MCO. The MCO must justify in the UM file the need for additional information and that the 14-day extension is in the member's interest.

[~~(14)~~] (12) The MCO shall provide written confirmation of its decisions within two working days of providing notification of a decision if the initial decision was not in writing.

[~~E.~~] F. **Use of clinical information:** When making a determination of coverage based on medical necessity, the MCO shall obtain relevant clinical information and consult with the treating practitioner, as appropriate.

(1) A written description shall identify the information required and collected to support UM decision making.

(2) A thorough assessment of the member's needs based on clinical appropriateness and necessity shall be performed.

(3) There will be documentation that relevant clinical information is gathered consistently to support UM decision making. The MCO UM policies and procedures will clearly define in writing for providers what constitutes relevant clinical information.

(4) The clinical information requirements for UM decision making shall be made known in advance to relevant treating providers.

[~~F.~~] G. **Denial of services:** A "denial" is nonauthorization of a request for care or services. The MCO shall clearly document and communicate the reason for each denial.

(1) The MCO shall require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease, such as the MCO's medical director.

[~~(1)~~] (2) The MCO shall make available to a requesting provider a physician reviewer to discuss, by telephone, denial decisions based on medical necessity.

[~~(2)~~] (3) The MCO shall send written notification to the member of the reason for each denial and to the provider, as appropriate.

[~~(3)~~] (4) The MCO shall recognize that a utilization review decision made

by the designated HSD official resulting from a fair hearing is final and shall be honored by the MCO, unless the MCO successfully appeals the decision through judicial hearing.

H. **Compensation for UM activities:** Each MCO contract must provide that, consistent with 42 CFR Sections 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

[~~G.~~] I. **Evaluation and use of new technologies:** The MCO and its delegates shall evaluate the inclusion of new medical technology and the new applications of existing technology in the benefit package. This includes the evaluation of clinical procedures and interventions, drugs and devices.

(1) The MCO shall have a written description of the process used to determine whether new medical technology and new uses of existing technologies shall be included in the benefit package.

(a) The written description shall include the decision variables used by the MCO to evaluate whether new medical technology and new applications of existing technology shall be included in the benefit package.

(b) The process shall include a review of information from appropriate government regulatory bodies as well as published scientific evidence.

(c) Appropriate professionals shall participate in the process to decide whether to include new medical technology and new uses of existing technology in the benefit package.

(2) An MCO shall not deem a technology or its application as experimental, investigational or unproven and deny coverage unless that technology or its application fulfills the definition of "experimental, investigational or unproven" contained in [~~the New Mexico Medical Assistance Program Policy Manual,~~] 8.325.6 NMAC.

[~~H.~~] J. **Evaluation of the UM process:** The MCO shall evaluate member and provider satisfaction with the UM process as a part of its member satisfaction survey. The MCO shall forward the evaluation results to HSD.

[~~I. Second Opinions: The MCO shall provide members the option of receiving a second opinion from another in-network provider when a member desires additional information regarding recommended treatment. The MCO may require a second opinion regarding proposed treatment as part of its utilization program.~~]

[~~J.~~] K. **HSD access:** HSD shall have access to the MCO's UM review documentation on request.

[8.305.8.13 NMAC - Rp 8 NMAC 4.MAD.606.7.4, 7-1-01; A, 7-1-04]

8.305.8.14 STANDARDS FOR CREDENTIALING AND RECREDENTIALING: The MCO shall document the mechanism for credentialing and recredentialing of providers with whom it contracts or employs to treat members outside the inpatient setting and who fall under its scope of authority and action. This documentation shall include, but not be limited to, defining the scope of providers covered, the criteria and the primary source verification of information used to meet the criteria, the process used to make decisions and the extent of delegated credentialing or recredentialing arrangements.

A. **Practitioner participation:** The MCO shall have a process for receiving input from participating providers regarding credentialing and recredentialing of providers.

B. **Primary source verification:** At the time of credentialing the provider, the MCO shall verify the following information from primary sources:

(1) a current valid license to practice;

(2) the status of clinical privileges at the institution designated by the practitioner as the primary admitting facility, if applicable;

(3) valid drug enforcement agency (DEA) or controlled substance registration (CSR) certificate, if applicable;

(4) education and training of providers, including graduation from an accredited professional program and the highest training program applicable to the academic or professional degree, discipline and licensure of the practitioner;

(5) board certification if the practitioner states on the application that the practitioner is board certified in a specialty;

(6) current, adequate malpractice insurance, according to the MCO's policy and if available to providers holding that type of license, and history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and

(7) primary source verification shall not be required for work history.

C. **Credentialing application:** The MCO shall use the HSD-approved credentialing form. [~~Until this form becomes available,~~] The provider shall complete a credentialing application that includes a statement by the applicant regarding:

(1) ability to perform the essential functions of the positions, with or without accommodation;

(2) lack of present illegal drug use;

(3) history of loss of license and felony convictions;

(4) history of loss or limitation of privileges or disciplinary activity;

(5) sanctions, suspensions or terminations imposed by medicare or medicaid; and

(6) applicant attests to the correctness and completeness of the application.

D. **External source verification:** Before a practitioner is credentialed, the MCO shall receive information on the practitioner from the following organizations and shall include the information in the credentialing files:

(1) national practitioner data bank, if applicable to the practitioner type;

(2) information about sanctions or limitations on licensure from the following agencies, as applicable:

(a) state board of medical examiners, state osteopathic examining board, federation of state medical boards or the department of professional regulations;

(b) state board of chiropractic examiners or the federation of chiropractic licensing boards;

(c) state board of dental examiners;

(d) state board of podiatric examiners;

(e) state board of nursing;

(f) the appropriate state licensing board for other practitioner types; and

(g) other recognized monitoring organizations appropriate to the practitioner's discipline.

(3) sanctions by medicare and medicaid, as applicable.

E. **Evaluation of practitioner site and medical records.** At the time of credentialing the MCO shall perform an initial visit to the offices of potential primary care providers, obstetricians, gynecologists and high volume behavioral health care practitioners prior to acceptance and inclusion as participating providers. The MCO shall determine its method for identifying high volume behavioral health practitioner.

(1) The MCO shall document a structured review to evaluate the site against the MCO's organizational standards and those specified by the managed care contract.

(2) The MCO shall document an evaluation of the medical record keeping practices at each site for conformity with the MCO's organizational standards.

F. **Recredentialing:** The MCO shall have formalized recredentialing procedures.

(1) The MCO shall formally recredential its providers at least every three years. During the recredentialing process

the MCO shall verify the following information from primary sources:

(a) a current valid license to practice;

(b) the status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;

(c) valid [~~drug enforcement agency (DEA)~~] DEA or CSR certificate, if applicable;

(d) board certification, if the practitioner was due to be recertified or became board certified since last credentialed or recredentialed;

(e) history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and

(f) a current, signed attestation statement by the applicant regarding:

(i) [~~reasons for inability~~] ability to perform the essential functions of the position, with or without accommodation;

(ii) lack of current illegal drug use;

(iii) history of loss or limitation of privileges or disciplinary action; and

(iv) current professional malpractice insurance coverage.

(2) There shall be evidence that, before making a recredentialing decision, the MCO has received information about sanctions or limitations on licensure from the following agencies, if applicable:

(a) the national practitioner data bank;

(b) medicare and medicaid;

(c) state board of medical examiners, state osteopathic examining board, federation of state medical boards or the department of professional regulations;

(d) state board of chiropractic examiners or the federation of chiropractic licensing boards;

(e) state board of dental examiners;

(f) state board of podiatric examiners;

(g) state board of nursing;

(h) the appropriate state licensing board for other practitioner types; and

(i) other recognized monitoring organizations appropriate to the practitioner's discipline.

(3) The MCO shall incorporate data from the following sources in its recredentialing decision-making process for providers:

(a) member complaints;

(b) information from quality management and improvement activities; and

(c) medical record reviews conducted as part of [~~the medical assistance division program manual section~~] Subsection E of 8.305.8.14 NMAC.

G. **Imposition of remedies:** The MCO shall have policies and procedures for altering the conditions of the practitioner's participation with the MCO based on issues of quality of care and service. These policies and procedures shall define the range of actions that the MCO may take to improve the provider's performance prior to termination.

(1) The MCO shall have procedures for reporting to appropriate authorities, including HSD, serious quality deficiencies that could result in a practitioner's suspension or termination.

(2) The MCO shall have an appeal process by which the MCO may change the conditions of a practitioner's participation based on issues of quality of care and service. The MCO shall inform providers of the appeal process in writing.

H. **Assessment of organizational providers:** The MCO shall have written policies and procedures for the initial and ongoing assessment of organizational providers with whom it intends to contract or which it is contracted. Providers include, but are not limited to, hospitals, home health agencies, nursing facilities, free-standing surgical centers, behavioral, psychiatric and addiction disorder facilities or services, residential treatment centers, clinics, 24-hour programs, behavioral health units of general hospitals and free-standing psychiatric hospitals. At least every three years, the MCO shall confirm that the provider is in good standing with state and federal regulatory bodies, including [~~the Human Services Department~~] HSD and, has been accredited or certified by the appropriate accrediting body and state certification agency or has met standards of participation required by the MCO.

(1) The MCO shall confirm that the provider has been certified by the appropriate state certification agency. Behavioral health organizational providers and services are certified by the following:

(a) DOH is the certification agency for organizational services and providers requiring certification, except for child and adolescent behavioral health services; and

(b) [~~the~~] CYFD is the certification agency for child and adolescent behavioral health organizational services and providers.

(2) The MCO shall confirm that the provider has been accredited by the appropriate accrediting body or has a detailed written plan [~~which~~] that could reasonably be expected to lead to accreditation within a reasonable period of time. Behavioral health organizational providers and services are accredited by the following:

(a) adult behavioral health organizational services or providers are accredited by the council on accreditation of rehabilitation facilities (CARF);

(b) child and adolescent accredited residential treatment centers are accredited by the joint commission on accreditation of healthcare organizations (JCAHO); other child behavioral health organizational services or providers are accredited by the council on accreditation (COA); and

(c) organizational services or providers who serve [~~both adults, children or~~] adults, children and adolescents are accredited by either CARF or COA.

[8.305.8.14 NMAC - Rp 8 NMAC 4.MAD.606.7.5, 7-1-01; A, 7-1-04]

8.305.8.15 PATIENT BILL OF RIGHTS: Under medicaid managed care, members have certain rights and responsibilities and the MCO shall have policies and procedures governing member rights and responsibilities. The following subsections shall be known as the "Patient Bill of Rights".

A. **Members' rights:**

(1) Members shall have a right to be treated equitably and with respect and recognition of their dignity and need for privacy.

(2) Medicaid members shall have a right to receive health care services in a non-discriminatory fashion.

(3) Members who have a disability shall have the right to receive any information in an alternative format in compliance with the Americans with Disabilities Act.

(4) Members or their legal guardians shall have a right to participate with their health care providers in decision making in all aspects of their health care, including the course of treatment [~~plan~~] development, acceptable treatments and the right to refuse treatment.

(5) Members or their legal guardians shall have the right to informed consent.

(6) Members or their legal guardians shall have the right to choose a surrogate decision-maker to be involved as appropriate, to assist with care decisions.

(7) Members or their legal guardians shall have the right to seek a second opinion [~~by another provider in the MCO network when members~~] from a qualified health care professional within the MCO network, or the MCO shall arrange for the member to obtain one outside the network, at no cost to the member. A second opinion may be requested, when the member or member's legal guardian need additional information regarding recommended treatment or believe the provider is not authorizing requested care.

(8) Members or their legal guardians shall have a right to voice grievances about the care provided by the MCO and to make use of the MCO's grievance process and the HSD fair hearings process without fear of retaliation.

(9) Members or their legal guardians shall have a right to choose from among the available providers within the limits of the plan network and its referral and prior authorization requirements.

(10) Members or their legal guardians shall have a right to make their wishes known through advance directives regarding health care decisions ([~~i. e.~~] e.g., living wills, right to die directives, "do not resuscitate" orders, etc.) consistent with federal and state laws and regulations.

(11) Members or their legal guardians shall have a right to access the member's medical records in accordance with the applicable federal and state laws and regulations.

(12) Members or their legal guardians shall have a right to receive information about: the MCO, its health care services, how to access those services, and the MCO network providers [~~and the patient bill of rights~~].

(13) Members or their legal guardians shall have the right to be free from harassment by the MCO or its network providers in regard to contractual disputes between MCOs and providers.

(14) Members have a right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.

[~~(14)~~] (15) Members or their legal guardians shall have the right to select an MCO and exercise switch enrollment rights without threats or harassment.

B. **Members' responsibilities:** Members or their legal guardians shall have certain responsibilities [~~which~~] that will facilitate the treatment process.

(1) Members or their legal guardians shall have a responsibility to provide, whenever possible, information that the MCO and providers need in order to care for them.

(2) Members or their legal guardians shall have a responsibility to understand the [~~members'~~] member's health problems and to participate in developing mutually agreed upon treatment goals.

(3) Members or their legal guardians shall have a responsibility to follow the plans and instructions for care that they have agreed upon with their providers.

(4) Members or their legal guardians shall have a responsibility to keep, reschedule or cancel an appointment rather than to simply not show up.

C. **MCO responsibilities:**

(1) The MCO shall provide a member handbook to its members[~~,~~] and to potential members who request the handbook. The MCO shall publish in the member handbook the members' rights and responsibilities from the patient bill of rights. MCOs shall honor the provisions set forth in the patient bill of rights.

(2) The MCOs shall comply with the grievance resolutions process found in [~~the Medical Assistance Division Program Manual 8.305.11 NMAC, Reimbursement for Managed Care~~] 8.305.12 NMAC, *MCO Member Grievance Resolution*.

(3) The MCO shall provide to members and their legal guardians the following information in writing or by telephone:

[~~(a) The MCO shall provide members or their legal guardians written information about benefits, including:~~

~~(i) benefits and services, including preventive and behavioral health services, included in and excluded from, coverage;~~

~~(ii) any special benefit provisions that may apply to services obtained outside the MCO system;~~

~~(iii) any restrictions on benefits that apply to services obtained outside the MCO's service area~~

~~(b) The MCO shall provide each member or legal guardian with written information about how to obtain primary and specialty care. This includes:~~

~~(i) a list of providers, by provider type and specialty, available through the MCO and how to access them;~~

~~(ii) how to obtain more information about providers who participate in the MCO;~~

~~(iii) how to obtain primary care services;~~

~~(iv) how to obtain specialty care, dental care, behavioral health services and hospital services;~~

~~(v) how to obtain care after normal office hours;~~

~~(vi) how to obtain emergency care, including the MCO's policy on when to directly access emergency care or use 911 services;~~

~~(vii) how to obtain care and coverage when out of the MCO's service area;~~

~~(viii) how the MCO shall notify members affected by the termination or change of a benefit, service or service delivery office or site.~~

~~(c) The MCO shall provide each member or legal guardian with written information about:~~

~~(i) the MCO's policy on freedom of provider choice;~~

~~(ii) procedures for changing assigned providers;~~

~~(iii) how to access toll-free hot lines;~~

~~(iv) how to file a grievance with the MCO and HSD;~~

~~(v) how to appeal a decision that adversely affects the member's coverage, benefits or other relationship with the MCO; and~~

~~(vi) the MCO's policies regarding other member rights and responsibilities.~~]

[~~(d)~~] (3) The MCO shall provide members or legal guardians with updated information within 30 days of a material change in the MCO provider network, procedures for obtaining benefits, the amount, duration or scope of the benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled, and information on grievance and fair hearing procedure.

[~~(e)~~] (4) The MCO shall provide members and legal guardians with access to a toll-free hot line for the MCO's program for grievance management. The toll-free hot line for grievance management shall include the following features:

[~~(i)~~] (a) requires no more than a two-minute wait except following mass enrollment periods;

[~~(ii)~~] (b) does not require a "touch-tone" telephone;

[~~(iii)~~] (c) allows communication with members whose primary language is not English or who are hearing impaired; and

[~~(iv)~~] (d) is in operation 24 hours per day, seven days per week.

[~~(4)~~] (5) The MCO shall provide active and participatory education of members or legal guardians that takes into account the cultural, ethnic and linguistic needs of members in order to assure understanding of the health care program, improve access and enhance the quality of service provided.

[~~(5)~~] (6) The MCO shall protect the confidentiality of member information and records.

(a) The MCO shall adopt and implement written confidentiality policies and procedures that conform to federal and state laws and regulations.

(b) The MCO's contracts with providers shall explicitly state expectations about confidentiality of member information and records.

(c) The MCO shall afford members or legal guardians the opportunity to approve or deny release by the MCO of identifiable personal information to a person or agency outside the MCO, except when release is required by law, state regulation or HSD quality standards.

(d) The MCO shall notify members and legal guardians in a timely manner when information is released in response to a court order.

(e) The MCO shall have written policies and procedures to maintain confidential information gathered or learned during the investigation or resolution of a complaint, including a member's status as a complainant.

(f) The MCO shall have written policies and procedures to maintain confidentiality of medical records used in quality review, measurement and improvement activities.

[~~(6)~~] (7) When the MCO delegates member service activity, the MCO shall retain responsibility for documenting MCO oversight of the delegated activity.

[~~(7)~~] (8) The MCO shall have written policies regarding the treatment of minors; adults who are in the custody of the state; adults who are the subject of an active protective services case with CYFD; children and adolescents who fall under the jurisdiction of CYFD and individuals who are unable to exercise rational judgment or give informed consent consistent with federal and state laws and New Mexico medicaid regulations. The policies regarding consent for treatment for these individuals shall be disseminated to providers within the MCO network.

[~~(8)~~] (9) The MCO shall have a process to detect, measure and eliminate operational bias or discrimination against enrolled medicaid members by the MCO providers.

[~~(9)~~] (10) The MCO shall ensure that its providers and their facilities comply with the Americans with Disabilities Act.

[~~(10)~~] (11) The MCO shall provide a member handbook to its members or potential members who request the handbook, and it shall be accessible via the internet.

[~~(11)~~] (12) The MCO shall develop and implement policies and procedures to allow members to access behavioral health services without going through the PCP. These policies and procedures must afford timely access to behavioral health services.

[~~(12)~~] (13) The MCO shall not restrict a member's right to choose a provider of family planning services.

[~~(13)~~] (14) The MCO's communication with members shall be responsive to the various populations by demonstrating cultural competence in the materials and services provided to members. The MCO shall provide information to its network providers about culturally relevant services and may provide information about alternative treatment options, e.g., American Indian healing practices if available. Information and materials provided by the MCO to medicaid members shall be written at a sixth-grade language level and shall be made available in [~~Spanish and English~~] the prevalent population.

[8.305.8.15 NMAC - Rp 8 NMAC 4.MAD.606.7.6, 7-1-01; A, 7-1-04]

8.305.8.16 STANDARDS FOR PREVENTIVE HEALTH SERVICES: The MCO shall follow current national standards for preventive health services. These standards are derived from several sources, including the U.S. preventive services task force, the centers for disease control and prevention; and the American college of obstetricians and gynecologists. Any preventive health guidelines developed by the MCO under these standards shall be adopted, reviewed at least every two years, updated when appropriate and disseminated to practitioner and member. Unless a member refuses and the refusal is documented, the MCO shall provide the following preventive health services or document that the services (with the results) were provided by other means. The MCO shall document medical reasons not to perform these services for an individual member. Member refusal is defined to include refusal to consent to and refusal to access care.

A. **Initial assessment:** The MCO shall perform an initial assessment of the member's health care needs within 90 days of the date the member enrolls in the MCO. For this purpose, a member is considered enrolled at the lock-in date.

B. **Immunizations:** The MCO shall adopt policies that to the extent possible, ensure that within six months of enrollment, members are immunized according to the type and schedule provided by current recommendations of the state department of health advisory committee on immunizations. The MCO shall provide the immunizations or verify the member's immunization history by a method acceptable to the health advisory committee.

C. **Screens:** The MCO shall adopt policies which will ensure that, to the extent possible, within six months of enrollment or within six months of a change in screening standards, asymptomatic members receive at least the following preventive screening services.

(1) *Screening for breast cancer*: Females aged 50-69 years shall be screened every one to two years by mammography alone or by mammography and annual clinical breast examination.

(2) *Screening for cervical cancer*: Female members with a cervix shall receive cytopathology testing starting at the onset of sexual activity, but at least by 18 years of age and every three years thereafter until reaching 65 years of age if prior testing has been consistently normal and the member has been confirmed not to be at high risk. If the member is at high risk, the frequency shall be at least annual.

(3) *Screening for colorectal cancer*: Members aged 50 years and older at normal risk for colorectal cancer shall be screened with annual fecal occult blood testing or sigmoidoscopy or colonoscopy, at a periodicity determined by the MCO.

(4) *Blood pressure measurement*: Members shall receive a blood pressure measurement at least every two years.

(5) *Serum cholesterol measurement*: Male members aged 35 and older and female members aged 45 and older who are at normal risk for coronary heart disease shall receive serum cholesterol and HDL cholesterol measurement every five years. Adults aged 20 or older with risk factors for heart disease shall have serum cholesterol and HDL cholesterol measurements.

(6) *Screening for obesity*: Members shall receive body weight and height/length measurements with each physical exam.

(7) *Screening for elevated lead levels*: Members aged 9-15 months (ideally at 12 months) shall receive a blood lead measurement at least once.

(8) *Screening for tuberculosis*: Routine tuberculin skin testing shall not be required for all members. The following high-risk persons shall be screened or previous screening noted: persons who immigrated from countries in Asia, Africa, Latin America or the Middle East in the preceding five years; persons who have substantial contact with immigrants from those areas; migrant farm workers; and persons who are alcoholic, homeless or injecting drug users. HIV-infected persons shall be screened annually. Persons whose screening tuberculin test is positive ≥10 mm of induration) must be referred to the local public health office in their community of residence for contact investigation.

(9) *Screening for rubella*: All female members of childbearing ages shall be screened for rubella susceptibility by history of vaccination or by serology.

(10) *Screening for chlamydia*: All sexually active female members age 25 or younger shall be screened for chlamydia. All female members over age 25 shall be screened for chlamydia if they inconsistently use barrier contraception, have more than one sex partner, or have had a sexually transmitted disease in the past.

(11) *Screening for type 2 diabetes*: Individuals with one or more of the following risk factors for diabetes shall be screened. Risk factors include a family history of diabetes (parent or sibling with diabetes); obesity (≥20% over desired body

weight or BMI ≥27kg/m2); race/ethnicity (e.g. Hispanic, Native American, African American, Asian-Pacific islander); previously identified impaired fasting glucose or impaired glucose tolerance; hypertension (≥140/90 mmHg); HDL cholesterol level ≤35 mg/dl and triglyceride level ≥250 mg/dl; history of gestational diabetes mellitus (GDM) or delivery of babies over 9 lbs.

(12) *Prenatal screening*: All pregnant members shall be screened for preeclampsia, D(Rh) incompatibility, down syndrome, neural tube defects, hemoglobinopathies, vaginal and rectal group B streptococcal infection and screened and counseled for HIV in accordance with the most current recommendations of the American college of obstetricians and gynecologists.

(13) *Newborn screening*: Newborn members shall be screened for those disorders specified in the state of New Mexico metabolic screen.

(14) *Tot-to-teen health checks*: The MCO shall operate a tot-to-teen mandated early and periodic screening, [~~Diagnosis~~] diagnostic and treatment (EPSDT) services as [~~outline in Medical Assistance Division Program Manual~~] outlined in 8.320.3 NMAC, *Tot-to-Teen Health Checks*. Within six months of enrollment, the MCO shall ensure that eligible members (up to age 21) are current according to the screening schedule (unless more stringent requirements are specified in these standards).

(15) Members over age 21 must be screened to detect high risk for behavioral health condition at his first encounter with a PCP after enrollment.

(16) The MCO shall require PCPs to refer clients, when appropriate, to behavioral health providers. The MCO shall assist the member with an appropriate behavioral health referral.

(17) The MCO shall require PCPs to use standardized alcohol and drug abuse screening tools, like the CAGE (cut down, annoyed, guilty or eye opener) or AUDIT (alcohol use disorders identification test) tools, for the high risk potential population. The frequency of screening shall be determined by the results of the first screen and other clinical indicators.

D. **Counseling:** The MCO shall adopt policies that shall ensure that applicable asymptomatic members are provided counseling on the following topics unless recipient refusal is documented:

(1) prevention of tobacco use;

(2) benefits of physical activity;

(3) benefits of a healthy diet;

(4) prevention of osteoporosis and heart disease in menopausal women citing the advantages and disadvantages of calcium and hormonal supplementation;

(5) prevention of motor vehicle injuries;

(6) prevention of household and recreational injuries;

(7) prevention of dental and periodontal disease;

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

(9) [~~to prevent~~] prevention of unintended [~~or mistimed~~] pregnancies.

E. **Hot line:** The MCO shall provide a toll-free health advisor telephone hot line function [~~which~~] that includes at least the following services and features:

(1) general health information on topics appropriate to the various medicaid populations, including those with severe and chronic physical and behavioral health conditions;

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

(3) prediagnostic and post-treatment health care decision assistance based on symptoms; and

(4) preventive/wellness counseling.

F. **Family planning:** The MCO must have a family planning policy. This policy must ensure that members of the appropriate age of both sexes who seek family planning services are provided with counseling and treatment [~~or referral to out-of-plan services (if it is not a covered medicaid service)~~], if indicated, as it relates to the following:

(1) methods of contraception; and

(2) [~~evaluation and treatment of infertility; and~~

~~(3)~~] HIV and other sexually transmitted diseases and risk reduction practices.

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

(1) educational outreach to all members of [~~child-bearing~~] childbearing age;

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

(3) risk assessment of all pregnant members to identify high-risk cases for special management;

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

(5) case management services to address the special needs of members who have a high risk pregnancy especially if risk is due to psychosocial factors such as substance abuse or teen pregnancy;

(6) screening for determination of need for a post-partum home visit; and

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

[8.305.8.16 NMAC - Rp 8 NMAC 4.MAD.606.7.7, 7-1-01; A, 7-1-04]

8.305.8.17 STANDARDS FOR MEDICAL RECORDS:

A. **Standards and policies:** The MCO shall require that member medical records be maintained on paper or electronic format. Member medical records shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review.

(1) The MCO shall have medical record confidentiality policies and procedures [~~according to~~] in compliance with state and federal guidelines and HIPAA.

(2) The MCO shall have medical record documentation standards that are enforced with its MCO providers and subcontractors and require that records reflect all aspects of patient care, including ancillary services. The documentation standards shall, at a minimum, require the following:

(a) patient identification information (on each page or electronic file);

(b) personal biographical data (age, sex, address, employer, school, home and work telephone numbers, name and telephone numbers of emergency contacts, marital status, consent forms and guardianship information);

(c) date of data entry and date of encounter;

(d) provider identification (author of entry);

(e) allergies and adverse reactions to medications;

(f) past medical history for patients seen three or more times;

(g) status of preventive services provided or at least those specified by HSD, summarized in an auditable form (a single sheet) in the medical record within six months of enrollment;

(h) diagnostic information;

(i) medication history;

(j) identification of current problems;

(k) history of smoking, alcohol use and substance abuse;

(l) reports of consultations and referrals;

(m) reports of emergency care, to the extent possible;

(n) advance directive for adults; and

(o) record legibility to at least a peer of the author.

(3) For patients who receive three or more services from a behavioral health provider within a 12-month period, the documentation standards shall meet MAD requirements and require the following items be included in the medical record, if applicable.

(a) a mental status evaluation which documents affect, speech, mood, thought content, judgment, insight, concentration, memory and impulse control;

(b) DSM-IV diagnosis consistent with the history, mental status examination or other assessment data;

(c) a treatment plan consistent with diagnosis [~~which~~] that has objective and measurable goals and time frames for goal attainment or problem resolution;

(d) documentation of progress toward attainment of the goal; and

(e) preventive services such as relapse prevention and stress management.

(4) The MCO standards for a member's medical record shall include the following minimum detail for individual clinical encounters:

(a) history and physical examination for the presenting complaints, including relevant psychological and social conditions affecting the patient's medical and psychiatric status;

(b) plan of treatment;

(c) diagnostic tests and the results;

(d) drugs prescribed, including the strength, amount, directions for use and refills;

(e) therapies and other prescribed regimens and the results;

(f) follow-up plans and directions (such as, time for return visit, symptoms that should prompt a return visit);

(g) consultations and referrals and the results; and

(h) any other significant aspect of patient care.

B. **Review of records:** The MCO shall have a process to systematically review provider medical records to ensure compliance with the medical record standards. The MCO shall institute improvement and actions when standards are not met.

(1) The EQRO shall conduct reviews of a representative sample of medical records from the MCO's primary care providers, obstetricians, gynecologists and behavioral health providers to determine compliance with the MCO's established medical record standards and goals.

(2) The MCO shall have a mechanism to assess the effectiveness of organization-wide and practice-site follow-up plans to increase compliance with the MCO's established medical record standards and goals.

C. **Access to records:** The MCO shall provide HSD or its designee appropriate access to provider medical records.

(1) The MCO shall ensure that the PCP [~~maintain~~] maintains a primary medical record for each member, which contains sufficient medical information from all providers involved in the member's care, to ensure continuity of care. The MCO shall ensure that providers involved in the member's care have access to the member's primary medical record.

(2) The MCO shall include provisions in its contracts with providers for appropriate access to the MCO's members' medical records for purposes of in-state quality reviews conducted by HSD or its agents and for making medical records available to health care providers for each clinical encounter.

(3) The MCO shall have an auditable policy that ensures the confidential transfer of medical, dental or behavioral health information to another primary medical, dental or behavioral health practitioner whenever a primary medical, dental or behavioral health provider leaves the MCO or whenever the member changes primary medical, dental or behavioral health practitioner or after a recipient changes enrollment from the MCO to enroll in another MCO. The information that shall be forwarded shall include, but not be limited to, the following:

(a) a list of the member's principal physical and behavioral health problems, as applicable;

(b) a list of the member's current medications, dosage amounts and frequency;

(c) the member's preventive health services history;

(d) EPSDT screening results (if the member is under age 21); and

(e) other information necessary to ensure continuity of care.

[8.305.8.17 NMAC - Rp 8 NMAC 4.MAD.606.7.8, 7-1-01; A, 7-1-04]

8.305.8.18 STANDARDS FOR ACCESS:

A. **Ensure access:** The MCO shall establish and follow protocols to ensure the accessibility, availability and referral to health care providers for each medically necessary service. The MCO must submit documentation to HSD at least once per year, giving assurances that it has the capacity to serve the expected enrollment in its service area in accordance with HSD standards and in a format acceptable to HSD. The MCO must provide access to the full array of covered services within the benefit package. If a service is unavailable based on the access guidelines, a service equal to or higher then must be offered.

B. **Access to urgent emergency services:** Services for emergency conditions, including emergency transportation [~~and~~], urgent conditions, and post-stabilization care shall be covered by the MCO only within the United States. An urgent condition exists when a [~~patient~~] member manifests acute symptoms and signs that, by reasonable medical judgment, represent a condition of sufficient severity that the absence of medical attention within 24 hours could reasonably result in an emergency condition. Serious impairment of biopsychosocial functioning, imminent out-of-home placement for children and adolescents or serious jeopardy to the behavioral health of the member are considered urgent conditions. An emergency condition exists when a [~~patient~~] member manifests acute symptoms and signs that, by reasonable [~~medical~~] lay person judgment, represent a condition of sufficient severity that the absence of immediate medical attention could reasonably result in death, serious impairment of bodily function or major organ and serious jeopardy to the overall health of the [~~patient~~] member. Post-stabilization care means covered services related to an emergency medical or behavioral condition, that are provided after the member is stabilized in order to maintain the stabilized condition and may include improving or resolving the member's condition.

(1) The MCO shall ensure that there is no clinically significant delay caused by the MCO's utilization control measures. Prior authorization is not required for emergency services in or out of the MCO network, and all emergency services shall be reimbursed at least at the medicaid fee-for-service rate. The MCO shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical or behavioral condition under the prudent lay person standard, turned out to be non-emergency in nature.

(2) The MCO shall ensure that the member has the right to use any hospital or other licensed emergency setting for emergency care, regardless of whether the provider is contracted with the MCO.

[~~(2)~~] (3) The MCO shall ensure that members have access to the nearest appropriately designated trauma center according to established EMS triage and transportation protocols.

C. **Primary care provider availability:** The MCO shall ensure that sufficient number of primary care providers are available to members to allow the mem-

bers a reasonable choice among providers.

(1) The MCO shall have at least one primary care provider available per 1,500 members.

(2) The minimum number of primary care providers from which to choose and the distances to those providers shall vary by county based on whether the county is urban, rural or frontier. Urban counties are: Bernalillo, Los Alamos, Santa Fe and Dona Ana. Frontier counties are: Catron, Harding, DeBaca, Union, Guadalupe, Hildago, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, Rio Arriba, San Miguel and Cibola. Rural counties are those that are not urban or frontier. The standards are as follows:

(a) 90% of urban residents shall travel no farther than 30 miles;

(b) 90% of rural residents shall travel no farther than 45 miles; and

(c) 90% of frontier residents shall travel no farther than 60 miles.

D. **Pharmacy provider availability:** The MCO shall ensure that a sufficient number of pharmacy providers are available to members. The MCO shall ensure that pharmacy services meet geographic access standards based on the member's county of residence. The access standards are as follows:

(1) 90% of urban residents shall travel no farther than 30 miles;

(2) 90% of rural residents shall travel no farther than 45 miles; and

(3) 90% of frontier residents shall travel no farther than 60 miles.

E. **Access to health care services:** The MCO shall ensure that there is a sufficient number of PCPs, dentists and behavioral health practitioners available to members to allow members a reasonable choice.

(1) The MCO shall report to HSD all provider groups, health centers and individual physician, dental or behavioral health practices and sites in their network that are not accepting new medicaid clients.

(2) For routine, asymptomatic, member-initiated, outpatient appointments for primary medical care, the request-to-appointment time shall be no more than 30 days, unless the member requests a later time.

(3) For routine asymptomatic member-initiated dental appointments, the request to appointment time shall be consistent with community norms for dental appointments.

(4) For routine, symptomatic, member-initiated, outpatient appointments for nonurgent primary medical and dental care, the request-to-appointment time shall be no more than 14 days, unless the member requests a later time.

(5) For nonurgent behavioral health care, the request-to-appointment time shall be no more than 14 days, unless the member requests a later time.

(6) Primary medical, dental and behavioral health care outpatient appointments for urgent conditions shall be available within 24 hours.

(7) For specialty outpatient referral and consultation appointments, excluding behavioral health, which is addressed in (5) above, the request-to-appointment time shall generally be consistent with the clinical urgency, but no more than 21 days, unless the member requests a later time.

(8) For routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, the request-to-appointment time shall be consistent with the clinical urgency, but no more than 14 days, unless the member requests a later time.

(9) For outpatient diagnostic laboratory, diagnostic imaging and other testing, if a "walk-in" rather than an appointment system is used, the member wait time shall be consistent with severity of the clinical need.

(10) For urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability shall be consistent with the clinical urgency, but no longer than 48 hours.

(11) The in-person prescription fill time (ready for pickup) shall be no longer than 40 minutes. A prescription phoned in by a practitioner shall be filled within 90 minutes.

(12) The timing of scheduled follow-up outpatient visits with practitioners shall be consistent with the clinical need.

(13) The MCO shall ensure that a medically necessary pharmaceutical agent is provided in a clinically timely manner.

(14) The MCO's formulary shall use HSD guidelines in [~~Medical Assistance Division Program Manual~~] Subsection O of 8.305.7.11 NMAC, *Services Included in the Salud! Benefit Package*, *Pharmacy Services*.

(15) The MCO shall approve or deny a request for new durable medical equipment (DME) or for repairs to existing DME owned or rented by the member within seven working days of the request date.

(a) All new customized or made-to-measure DME or customized modifications to existing DME owned or rented by the member shall be delivered to the member within 150 days of the request date.

(b) All standard DME shall be delivered within 24 hours of the request, if needed on an urgent basis.

(c) All standard DME not needed on an urgent basis shall be delivered within a time frame consistent with clinical need.

(d) All DME repairs or noncustomized modifications shall be delivered within 60 days of the request date.

(e) The MCO shall have an emergency response plan for noncustomized DME needed on an emergent basis.

(16) The MCO shall approve or deny a request for prescribed medical supplies within seven working days of the request date. The MCO shall ensure that:

(a) members can access prescribed medical supplies within 24 hours when needed on an urgent basis;

(b) members can access routine medical supplies within a time frame consistent with the clinical need;

(c) subject to any requirements to procure a physician's order to provide supplies to the member, members utilizing medical supplies on an ongoing basis shall submit to the MCO lists of needed supplies monthly; and the MCO or its subcontractor shall contact the member if the requested supplies cannot be delivered in the time frame expected and make other delivery arrangements consistent with clinical need.

(17) The MCO shall have an emergency response plan for delivery of medical supplies needed on an emergent basis.

(18) The MCO shall ensure that members and members' families receive proper instruction on the use of DME and medical supplies provided by the MCO or its subcontractor.

F. **Access to transportation services:** The MCO shall provide the transportation benefit for medically necessary health services. The MCO shall have sufficient transportation providers available to meet the needs of members, including an appropriate number of handivans available for members who are wheelchair or ventilator dependant or have other equipment needs. The MCO shall develop and implement policies and procedures to ensure that:

(1) transportation arranged is appropriate for the member's clinical condition;

(2) the history of services is available at the time services are requested to expedite appropriate arrangements;

(3) CPR-certified drivers are available to transport members consistent with clinical need;

(4) the transportation type is clinically appropriate, including access to non-emergency ground ambulance carriers;

(5) members can access and receive authorization for medically necessary transportation services under certain unusual circumstances without advance notification; and

[~~(6) a minor is provided safe transportation if a parent or legal guardian will not be present; and~~]

[~~(7)~~] (6) [~~transportation vehicles~~

~~are equipped with a communication device for use in case of emergency~~] minors are accompanied by a parent or legal guardian as indicated to provide safe transportation.

G. **Use of technology:** The MCO is encouraged to use state-of-the-art technology, such as telemedicine, to ensure access and availability of services statewide.

[8.305.8.18 NMAC - Rp 8 NMAC 4.MAD.606.7.9, 7-1-01; A, 7-1-04]

8.305.8.19 DELEGATION: Delegation is a process whereby an MCO gives another entity the authority to perform certain functions on its behalf. The MCO is fully accountable for all delegated activities and decisions made. The MCO shall document its oversight of the delegated activity. The MCO shall not delegate behavioral health functions and activities, including quality oversight, utilization management prevention, education, outreach, grievance resolution, data collection and claims payment.

A. A mutually agreed upon document between MCO and the delegated entity will describe:

(1) the responsibilities of the MCO and the entity to [~~whom~~] which the activity is delegated;

(2) the delegated activity;

(3) the frequency and method of reporting to the MCO;

(4) the process by which the MCO evaluates the delegated entity's performance; and

(5) the remedies up to, and including, revocation of the delegation, available to the MCO if the delegated entity does not fulfill its obligations.

B. The MCO shall document evidence that the MCO:

(1) evaluated the delegated entity's capacity to perform the delegated activities prior to delegation;

(2) evaluates regular reports; and

(3) evaluates semi-annually the delegated entity's activities in accordance with the MCO's expectations and HSD standards.

[8.305.8.19 NMAC - N, 7-1-01; A, 7-1-04]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.10 NMAC, Sections 9, 11 and 12, which will be effective on July 1, 2004. The Medical Assistance Division amended the section in order to comply with the Health Insurance Portability and Accountability Act (HIPAA).

8.305.10.9 ENCOUNTERS: MCOs shall submit encounter data to [~~the state~~] HSD under requirements established by HSD. HSD maintains oversight responsibility for evaluating and monitoring the volume, timeliness and quality of encounter data submitted by the MCOs. If an MCO contracts with a third party to process and submit encounter data, the MCO remains responsible for the quality, accuracy and timeliness of the encounter data submitted to HSD. HSD shall communicate directly with the MCO, not with the third party contractor, regarding requirements, deficiencies, quality, accuracy and timeliness of encounter data.

[8.305.10.9 NMAC - Rp 8 NMAC 4.MAD.606.9, 7-1-01; A, 7-1-04]

8.305.10.11 ENCOUNTER SUBMISSION TIME FRAMES: The MCOs shall submit encounter data to HSD within [~~90 days~~] 120 days of the service delivery date or discharge. HSD shall establish error thresholds, time frames and procedures for the submission, correction and resubmission of encounter data.

[8.305.10.11 NMAC - Rp 8 NMAC 4.MAD.606.9.2, 7-1-01; A, 7-1-04]

8.305.10.12 ENCOUNTER DATA ELEMENTS: Encounter data elements are based on the medicaid-medicare common data initiative (mcdata set), which is a minimum core data set for states and MCOs developed by [~~the Health Care Financing Administration and the Human Services Department~~] CMS and HSD for use in managed care. Encounter data elements are specified in the managed care contract. The human services department may increase or reduce or make mandatory or optional, data elements as it deems necessary.

[8.305.10.12 NMAC - Rp 8 NMAC 4.MAD.606.9.3, 7-1-01; A, 7-1-04]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.11 NMAC, Section 9, which will be effective on July 1, 2004. The Medical Assistance Division amended the section in order to comply with the Health Insurance Portability and Accountability Act (HIPAA).

8.305.11.9 REIMBURSEMENT FOR MANAGED CARE:

A. **Payment for services:** HSD shall [~~pay a capitated amount to contracted MCOs in payment for providing the managed care benefit package at a rate specified in the managed care contract.~~] make actuarially sound payments under capitated risk contracts to the designated MCOs. Rates must be appropriate for the populations to be covered and the services to be furnished under the contract. The MCO shall be responsible for [~~provisions~~] the provision of services for members during the month of capitation. Medicaid members shall not be liable for debts incurred by an MCO under the MCO's managed care contract for providing health care to medicaid members. [~~HSD shall pay interest at 9% per annum on any capitation payment due to the MCO that is more than 30 days late. No interest or penalty shall accrue for any other late payments or reimbursements.~~] This will include, but not be limited to:

(1) the MCO's debts in the event of the MCO's insolvency;

(2) covered services provided to the member, for which HSD does not pay the MCO, e.g., enhanced services;

(3) when HSD or the MCO does not pay the health care provider that furnishes the services under contractual, referral, or other arrangement; and

(4) payments for covered services furnished under contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the MCO provided the service directly.

B. **Capitation disbursement requirements:** The MCO shall accept the capitation rate paid each month by HSD as payment in full for all services to be provided pursuant to the agreement, including all administrative costs associated therewith. A minimum of eighty-five percent (85%) of all the MCO's income generated under this agreement, including but not limited to, third-party recoupments and interest, shall be expended on the medical and behavioral health services required under this agreement to be provided to the MCO's medicaid members. If the MCO does not expend a minimum of eighty-five percent (85%) on medical and behavioral services required under the agreement, HSD will withhold an amount so that the MCO's ratio for service expenditures are eighty-five percent (85%). HSD will calculate the MCO's income at the end of the state fiscal year to determine if eighty-five percent (85%) was expended on the medical and behavioral services required under the agreement, utilizing reported information and the department of insurance reports. Administrative costs, which must be no higher than fifteen (15%), and other financial information will be monitored on a regular basis by HSD. Members shall be entitled to receive all covered services for the entire period for which payment has been made by HSD. Any and all costs incurred by the MCO in excess of the capitation payment will be borne in full by the MCO. Interest generated through investment of

funds paid to the MCO pursuant to this agreement shall be the property of the MCO.

[~~B.~~] C. **Payment time frames:** Clean claims as defined in [~~8.305.1.7.K NMAC, DEFINITIONS,~~] Subsection L of 8.305.1.7 NMAC, *Clean Claim*, shall be paid by the MCO to contracted and noncontracted providers according to the following timeframe: 90% within 30 days of the date of receipt and 99% within 90 days of the date of receipt, as required by federal guidelines in the Code of Federal Regulations, Section 42 CFR 447.45. The date of receipt is the date the MCO receives the claim, as indicated by the MCO's date stamp on the claim. The date of payment is the date of the check or other form of payment. An exception to this rule may be made if the MCO and its providers, by mutual agreement, establish an alternative payment schedule; however, any such alternative payment schedule must first be incorporated into the contract between HSD and the MCO. The MCO shall promptly pay claims for all covered emergency and post-stabilization services that are furnished by noncontracted providers, including medically necessary testing to determine if a medical emergency exists.

(1) An MCO shall pay contracted and noncontracted providers interest on the MCO's liability at the rate of 1 1/2 % per month on the amount of a clean claim (based upon the current medicaid fee schedule) submitted by the participating provider and not paid within 30 days of the date of receipt of an electronic claim and 45 days of receipt of a manual claim. Interest will accrue from the 31st day for electronic claims and from the 46th day for manual claims.

(2) No contract between an MCO and a participating provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions.

(3) If an MCO is unable to determine liability for, or refuses to pay, a claim of a participating provider within the times specified above, the MCO shall make a good-faith effort to notify the participating provider by fax, electronic or other written communication within 30 days of receipt of the claim, stating specific reasons why it is not liable for the claim or request specific information necessary to determine liability for the claim.

[~~C.~~] D. **Rate setting:** Capitation rates paid by HSD to the MCOs for the provision of the managed care benefit package shall be calculated through actuarial analysis, be actuarially sound and meet the standards set by 42 CFR 438.6(c).

[~~D.~~] E. **Payment on risk basis:** The MCO is at risk of incurring losses if its costs of providing the managed care benefit package exceed its capitation payment. HSD shall not provide retroactive payment adjustments to the MCO to reflect the actual cost of services furnished by the MCO.

[~~E.~~] F. **Change in capitation rates:** HSD shall review the capitation rates 12 months from the effective date of the managed care contract and annually thereafter. HSD may adjust the capitation rates based on factors such as changes in the scope of work, [~~a Native American MCO is established or a Navajo medicaid agency created, HCFA~~] CMS requires a modification of the state's waiver [~~or~~] , if new or amended federal or state laws or regulations are implemented, or inflation or significant changes in the demographic characteristics of the member population occur.

[~~F.~~] G. **Solvency requirements and risk protections:** An MCO which contracts with HSD to provide medicaid services shall comply with, and be subject to, all applicable state and federal laws and regulations, including solvency and risk standards. In addition to requirements imposed by state and federal law, the MCO shall be required to meet specific medicaid financial requirements and to provide to HSD, or its agent, information and records necessary to determine the MCO's financial condition. Requests for information and records shall be delivered to HSD, at no cost to HSD, in a reasonable time after the date of request or as specified in the managed care contract.

(1) **Reinsurance:** An MCO participating in medicaid managed care shall purchase reinsurance. The MCO shall document for HSD that reinsurance is in effect through the term of the medicaid managed care contract and that the amount of reinsurance is sufficient to cover probable outlier cases or overall member utilization at an amount greater than expected. Pursuant to 42 CFR Section 438.6(e)(5), contract provisions for reinsurance, stop-loss limits, or other risk sharing methodologies must be computed on an actuarially sound basis.

(2) **Third party liability (TPL):** By federal law medicaid is the payer of last resort. The MCO shall be responsible for identifying a member's third party coverage and coordinating of benefits with third parties. The MCO shall inform HSD when a member has other health care insurance coverage. [~~The MCO shall provide documentation to HSD to enable HSD to pursue its rights under state and federal law. HSD shall be responsible for tort and estate recovery.~~] The MCO shall provide to HSD for audit and review all records pertaining to TPL collections for members.

(3) **Fidelity bond requirement:** The MCO shall maintain a fidelity bond in the maximum amount specified under the Insurance Code.

(4) **Net worth requirement:** The MCO shall comply with the net worth requirements of the Insurance Code.

(5) **Solvency cash reserve requirement:** The MCO shall have sufficient reserve funds available to ensure that the provision of services to medicaid members is not at risk in the event of MCO insolvency.

(6) **Per enrollee cash reserve:** [~~The MCO shall maintain 3% of the monthly capitated payment per member made by HSD to the MCO with an independent trustee during each month of the first year of the medicaid managed care contract. The MCO shall maintain this cash reserve for the duration of the contract plus 120 days. HSD may adjust this cash reserve requirement based on the average number of enrolled MCO members.~~] The MCO shall maintain three (3) percent of the monthly capitation payments per member with an independent trustee during each month of the first year of the agreement; provided, however, that if this agreement replaces or extends a previous agreement with HSD to provide medicaid managed care, then continued maintenance of the per member cash reserve established and maintained by the MCO pursuant to such previous agreement shall be the agreement. HSD shall adjust this cash reserve requirement annually, or as needed, based on the number of the MCO's members. Each MCO shall maintain its own cash reserve account. This account may be accessed solely for payment for services to the MCO's members in the event that the MCO becomes insolvent. Money in the reserve account remains the property of the MCO, and any interest earned (even if retained in the account) shall be the property of the MCO.

[~~G.~~] H. **Inspection and audit for solvency requirements:** The MCO shall meet all requirements for state licensure with respect to inspection and auditing of financial records. The MCO shall cooperate with HSD or its designee to provide all financial records required by HSD. HSD or its designee may inspect and audit the MCO's financial records at least annually, or more frequently, if deemed necessary.

[~~H.~~] I. **Special payment requirements:** This section lists special payment requirements by provider type.

(1) **Reimbursement for FQHCs:** Under federal law, FQHCs shall be reimbursed at 100% of reasonable cost under a medicaid fee-for-service or managed care program. The FQHC may waive its right to 100% of reasonable cost and elect to receive a rate negotiated with the MCO. HSD shall provide a discounted wrap-around payment to FQHCs [~~which~~] that have waived a right to 100% reimbursement of reasonable cost

from the MCO.

(2) **Reimbursement for providers furnishing care to Native Americans:** If an Indian health service (IHS) or tribal 638 provider delivers services to an MCO member who is Native American, the MCO shall reimburse the provider at the rate currently established by the office of management and budget (OMB) for specified services for the IHS facilities [~~or federally leased facilities by the Office of Management (OMB) or Medicaid or~~] , or the medicaid fee-for-service rate for all other services or at a fee negotiated between the provider and the MCO.

(3) **Reimbursement for family planning services:** The MCOs shall reimburse out-of-network family planning providers for services provided to MCO members at a rate at least equal to the medicaid fee-for-service rate for the provider type.

(4) **Reimbursement for women in the third trimester of pregnancy:** If a woman in the third trimester of pregnancy at the time of her enrollment in Salud! has an established relationship with an obstetrical provider and desires to continue that relationship and the provider is not contracted with the MCO, the MCO shall reimburse the out-of-network provider for care directly related to the pregnancy, including delivery and a six-week post-partum visit.

(5) **Reimbursement for members who disenroll while hospitalized:** If a member is hospitalized at the time of disenrollment, the MCO shall be responsible for payment of all covered inpatient facility and professional services from the date of admission to the date of discharge. The MCO shall be responsible for ensuring proper transition of care if the member is to be enrolled with another MCO.

(6) **Reimbursement for personal care option assessment/utilization review management services:** Payment for PCO services provided by the MCO to manage PCO utilization shall be paid to the MCO on a negotiated fee-for-service basis.

(7) **Reimbursement for non-Salud! Native Americans:** The MCO shall be paid a negotiated capitated per member per month rate to provide the transportation and pharmacy benefits to non-Salud! Native American enrollees not currently in long-term care services.

(8) **Reimbursement for primary care case management:** The provider/agency contracted for primary care case management shall receive a negotiated per member per month fee-for-services rendered.

[~~(6)~~] (9) **Sanctions for noncompliance:** The department may impose sanctions against an MCO that fails to meet the financial requirements specified in this section or additional requirements specified in the terms of the medicaid managed care contract or federal medicaid law.

J. **Recoupment payments:** HSD shall have the discretion to recoup payments for members who are incorrectly enrolled with more than one MCO, including members categorized as newborns or X5; payments made for members who die prior to the enrollment month for which payment was made; and/or payments for members whom HSD later determines were not eligible for medicaid during the enrollment month for which payment was made. Any duplicate payment identified by either the MCO or HSD will be recouped upon identification. Notwithstanding the foregoing, in the absence of fraud on the part on the MCO, HSD shall not have the right to recoup any payment to the MCO if either the MCO (and/or its subcontractors) provided any health care services to the member during the 60 days following the first day of any month for which payment was made or more than twenty-four months have elapsed since the payments were made unless HSD is required by federal agency to go beyond the twenty-four month period. To allow for claim submission lags, HSD will not request a payment recoupment until 120 days have elapsed from the date of which the enrollment/claims payment error was made. In the event of an error which causes payment(s) to the MCO to be issued by HSD, the MCO shall reimburse the state within thirty (30) days of written notice of such error for the full amount of the payment, subject to the provisions of Section 5.6(4) of the agreement. Interest shall accrue at the statutory rate on any amounts not paid and determined to be due after the thirtieth (30th) day following the notice. Any process that automates the recoupment procedures will be mutually agreed upon in advance by HSD and the MCO and documented in writing, prior to implementation of the new automated recoupment process. The MCO has the right to dispute any recoupment request in accordance with Article 15 (DISPUTES).

K. HSD shall pay interest at 9% per annum on any capitation payment due to the MCO that is more than 30 days late. No interest or penalty shall accrue for any other late payments or reimbursements.

L. HSD may initiate alternate payment methodology for specified program services or responsibilities.

[8.305.11.9 NMAC - Rp 8 NMAC 4.MAD.606.10, 7-1-01; A, 7-1-04]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.14 NMAC, Sections 10 & 12, which will be effective on July 1, 2004. The Medical Assistance Division amended the section in order to comply with the Health Insurance Portability and Accountability Act (HIPAA).

8.305.14.10 REPORTING STANDARDS:

A. Reports submitted by the MCO to HSD shall meet certain standards.

(1) The MCO shall verify the accuracy of data and other information on reports submitted to HSD.

(2) Reports or other required data shall be received on or before scheduled due dates.

(3) Reports or other required data shall conform with HSD defined standards[~~;~~ ~~and~~].

(4) All required information shall be fully disclosed in a manner that is responsive and with no material omission.

(5) The MCO shall analyze all required reports internally before submitting them to HSD. The MCO shall analyze the report for any early patterns of change, identified trend, or outlier. The MCO shall send a written narrative with the report documenting the MCO's interpretation of the early pattern of change, identified trend, or outlier.

B. **Consequences of violation of reporting standards:** The submission of late, inaccurate or otherwise incomplete reports shall be considered failure to report. Sanctions may be imposed by HSD on the MCO for failure to submit accurate and timely reports.

C. **Changes in requirements:** HSD requirements regarding reports, report content and frequency of submission may change during the term of the managed care contract. The MCO shall comply with changes specified by HSD.

[8.305.14.10 NMAC - Rp 8 NMAC 4.MAD.606.13.1, 7-1-01; A, 7-1-04]

8.305.14.12 FINANCIAL REPORTS: Financial reports demonstrate the MCO's ability to meet its commitments under the terms of the managed care contract. The format, content and frequency for submitting financial reports shall be determined by HSD. The MCO shall meet the following general requirements:

A. The MCO shall submit annual audited financial statements, including but not limited to, its income statement,

a statement of changes in financial condition or cash flow and a balance sheet, and shall include an audited schedule of Salud! revenues and expenses including a breakout of the Salud! behavioral health revenue and expenses. The result of the MCO's annual audit and related management letters shall be submitted no later than 150 days following the close of the MCO's fiscal year. The audit shall be performed by an independent certified public accountant. The MCO shall submit for examination any financial reports requested by HSD.

B. The MCO and its subcontractors shall maintain their accounting systems in accordance with statutory accounting principles, generally accepted accounting principles, or other generally accepted system of accounting. The accounting system shall clearly document all financial transactions between the MCO and its subcontractors and the MCO and HSD. These transactions shall include, but not be limited to, claim payments, refunds and adjustment of payments.

C. The MCO and its subcontractors shall make available to HSD and other authorized state or federal agency, all financial records required to examine compliance by the MCO, in so far as those records are related to MCO performance under the Salud! contract. The MCO and its subcontractors shall provide HSD access to its facilities for the purpose of examining, reviewing and inspecting the MCO's records.

D. The MCO and its subcontractors shall retain all records and reports relating to agreements with HSD for a minimum of six years after the date of final payment. In cases involving incomplete audits and unresolved audit findings, administrative sanctions or litigation, the minimum six year retention period shall begin on the date such actions are resolved.

E. The MCO is mandated to notify HSD immediately when any change in ownership is anticipated. The MCO shall submit a detailed work plan within 30 days of approval of the sale by the department of insurance that identifies areas of the contract that will be impacted by the change in ownership, including management and staff. The MCO shall submit records involving any business restructuring when changes in ownership interest in the MCO of 5% or more have occurred. These records shall include, but shall not be limited to, an updated list of names and addresses of all persons or entities having ownership interest in the MCO of 5% or more. These records shall be provided no later than 60 days following the change in ownership.

[8.305.14.12 NMAC - Rp 8 NMAC 4.MAD.606.13.3, 7-1-01; A, 7-1-04]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.16 NMAC, Section 9, which will be effective on July 1, 2004. The Medical Assistance Division amended the section in order to comply with the Health Insurance Portability and Accountability Act (HIPAA).

8.305.16.9 CLIENT TRANSITION OF CARE: The MCO shall actively assist with transition of care issues. [~~Medicaid eligible~~] Medicaid-eligible clients may initially receive medical services under fee-for-service medicaid prior to enrollment in managed care. During the member's medicaid eligibility period, enrollment status with a particular MCO may change and the member may switch enrollment to a different MCO. Certain members covered under managed care may become exempt and other members may lose their medicaid eligibility while enrolled in an MCO. A member changing from MCO to MCO, fee-for-service to managed care coverage and vice versa shall continue to receive medically necessary services in an uninterrupted manner. The MCO shall have the resources and policies and procedures in place to ensure continuity of care without disruption in service to members and to assure the service provider of payment.

A. **Member transition:** The MCO shall have policies and procedures that address member identification and the clinical transition and transfer of members into or out of the MCO.

(1) The MCO shall have policies and procedures that cover potentially large or mass transfer of members into or out of the MCO, including the identification of members currently receiving services.

(2) The MCO shall have policies and procedures covering the transition into the MCO of an individual member, which shall include member and provider education about the MCO and the review and update of existing [~~treatment plans~~] courses of treatment.

(3) The MCO shall have policies and procedures that identify members transferring out of the MCO and ensure the provision of member data and clinical information to the future MCO necessary to avoid delays in member treatment. The MCO shall have written policies and procedures to facilitate a smooth transition of a member to another MCO, when a member chooses and is approved to switch to another MCO.

(4) The MCO shall have policies and procedures regarding provider responsibility for discharge planning upon the member's discharge from an inpatient or residential treatment facility, and the MCO shall help coordinate for a seamless transition of post-discharge care.

B. **Prior authorization and provider payment requirements:**

(1) For newly enrolled members, the MCO shall honor all prior approvals granted by HSD through its contractors for the first 30 days of enrollment or until the MCO has made other arrangements for the transition of services. Providers who delivered services approved by HSD through its contractors shall be reimbursed by the MCO.

(2) For members who recently became exempt from Salud!, HSD shall honor prior approval of fee-for-service covered benefits granted by the MCO for the first 30 days under fee-for-service medicaid or until other arrangements for the transition of services have been made. Providers who deliver these services and are eligible and willing to enroll as medicaid fee-for-service providers shall be reimbursed by HSD.

(3) For members who had transplant services approved by HSD under fee-for-service, the MCO shall reimburse the providers approved by HSD if a donor organ becomes available for the member during the first 30 days of enrollment.

(4) For members who had transplant services approved by the MCO, HSD shall reimburse the providers approved by the MCO if a donor organ becomes available for the member during the first 30 days under fee-for-service medicaid. Providers who deliver these services shall be eligible and willing to enroll as medicaid fee-for-service providers.

(5) For newly enrolled members, the MCO shall pay for prescriptions for drug refills for the first 30 days or until the MCO has made other arrangements.

(6) For members who recently became exempt from Salud!, HSD shall pay for prescriptions for drug refills for the first 30 days under the fee-for-service formulary. The pharmacy provider shall be eligible and willing to enroll as a medicaid fee-for-service provider.

(7) The MCO shall pay for DME costing $2,000 or more, approved by the MCO but delivered to the member after disenrollment from Salud!.

(8) HSD shall pay for DME costing $2,000 or more, approved by HSD but delivered to the member after enrollment in the MCO. The DME provider shall be eligible for and willing to enroll as a medicaid fee-for-service provider.

C. **Special payment requirement.** The MCO shall be responsible for payment of covered medical services, including behavioral health care, provided to the member for any month the MCO

receives a capitation payment, even if the member has lost medicaid eligibility.

D. **Claims processing and payment:** In the event that an MCO's contract with HSD has ended, is not renewed or is terminated, the CONTRACTOR shall remain responsible for processing and paying claims for services delivered through the contract period, but submitted after the MCO's contract has ended.

(1) The MCO shall be required to inform providers in writing, at least 30 days prior to the end of the contract, of the termination of the contract and of the process for providers to submit claims for services provided through the contract end date. The letter shall include the telephone, fax numbers, and the billing address for claims submissions as well as the names of persons to contact with questions.

(2) The MCO shall allow six months to process claims for services provided prior to the contract termination date.

(3) The MCO shall continue to meet timeframes established for processing all claims.

[8.305.16.9 NMAC - N, 7-1-01; A, 7-1-04]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.310.6 NMAC, Sections 12 and 14, which will be effective on July 1, 2004. The Medical Assistance Division amended these sections to show that one routine eye exam, one set of corrective lenses and one frame for an adult in a 24-month period is covered.

8.310.6.12 COVERED SERVICES: Medicaid covers specific vision care services that are medically necessary for the diagnosis and treatment of eye diseases and for the correction of refractive errors, as required by the condition of the recipient. All services must be furnished within the limits of medicaid benefits, within the scope and practice of the medical professional as defined by state law and in accordance with applicable federal, state, and local laws and regulations.

A. **Exam:** Medicaid covers routine eye exams. Coverage for adults is limited to one routine eye exam [~~for an adult in a twelve-month period~~] in a twenty-four-month period. Exams for an existing medical condition, such as diabetes, will be covered for required follow-up and treatment. The medical condition must be clearly documented on the visual examination form and indicated by diagnosis on the claim.

B. [~~**Eyeglasses:** Medicaid covers~~] **Corrective lenses:** Medicaid covers corrective lenses. Coverage for adults is limited to one set of corrective lenses [~~for an adult in a twelve-month~~] in a twenty-four-month period, unless an ophthalmologist or optometrist recommends a change in prescription due to a medical condition affecting vision. The vision prescription must be appropriately recorded on the visual examination form.

(1) For the purchase of eyeglasses, the diopter correction must meet or exceed one of the following diopter correction criteria:

(a) -1.00 myopia (nearsightedness);

(b) + 1.00 for hyperopia (farsightedness);

(c) +0.75 astigmatism (distorted vision);

(d) ± 1.00 for presbyopia (farsightedness of aging); or

(e) +2.00 for diplopia (double vision) - prism lenses.

(2) If an existing prescription is updated, there must be a minimum 0.75 diopter change in the prescription. Exceptions are considered [~~with prior authorization~~] for the following:

(a) recipients with cataracts; or

(b) recipients under twenty-one (21) years of age.

[~~(3) Medicaid covers one frame for corrective lenses for an adult in a twenty-four month period.~~

~~(4) Eyeglasses or contact lenses that are lost, broken or have deteriorated to the point that, in the examiner's opinion, they have become unusable to the recipient, may be replaced for the following:~~

~~(a) recipients under twenty-one (21) years of age; or~~

~~(b) recipients twenty-one (21) years of age or older who have developmental disabilities.~~

~~(5) Documentation for replacement:~~

~~(a) the eyeglasses or contact lens (or lenses) must meet the diopter correction purchase criterion and must be recorded on the report of visual examination form; and~~

~~(b) the loss, deterioration or breakage must be documented in the appropriate section of the visual examination form.~~

~~(6) Medicaid covers bifocal lenses with a correction of 0.25 or more for distance vision and 1 diopter or more for added power (bifocal lens correction).~~

~~(7) Medicaid covers tinted lenses with filtered or photochromic lenses if the examiner documents one or more of the following disease entities, injuries, syndromes or anomalies in the "comments" section of the visual examination form, and the prescription meets the dioptic correction purchase criteria:~~

~~(a) aniridia;~~

~~(b) albinism, ocular;~~

~~(c) traumatic defect in iris;~~

~~(d) iris coloboma, congenital;~~

~~(e) chronic keratitis;~~

~~(f) Sjogren's syndrome;~~

~~(g) aphakia, U.V. filter only if intraocular lens is not U.V. filtered; and~~

~~(h) rod monochromaly.~~

~~C. **Balance lenses:** Medicaid covers balance lenses without prior authorization in the following situations:~~

~~(1) lenses used to balance an aphakic eyeglass lens; or~~

~~(2) recipient is blind in one eye and the visual acuity in the eye requiring correction meets the diopter correction purchase criteria.~~

~~D. **Contact lenses:** Medicaid covers contact lenses, either the original prescription or replacement, only with prior authorization. Requests for prior authorization will be evaluated on dioptic criteria and/or visual acuity, the recipient's social or occupational need for contact lenses, and special medical needs. The criteria for authorization of contact lenses are as follows:~~

~~(1) the recipient must have a diagnosis of keratoconus or diopter correction of +/- 6.00 or higher in any meridian, at least 3.00 diopters of anisometropia.~~

~~(2) monocular aphakies may be provided with one contact lens and a pair of bifocal glasses.~~]

C. **Bifocal lenses:** Medicaid covers bifocal lenses with a correction of 0.25 or more for distance vision and 1 diopter or more for added power (bifocal lens correction).

D. **Tinted lenses:** Medicaid covers tinted lenses with filtered or photochromic lenses if the examiner documents one or more of the following disease entities, injuries, syndromes or anomalies in the "comments" section of the visual examination form, and the prescription meets the dioptic correction purchase criteria:

(1) aniridia;

(2) albinism, ocular;

(3) traumatic defect in iris;

(4) iris coloboma, congenital;

(5) chronic keratitis;

(6) sjogren's syndrome;

(7) aphakia, U.V. filter only if intraocular lens is not U.V. filtered; and

(8) rod monochromaly.

E. **Balance lenses:** Medicaid covers balance lenses without prior authorization in the following situations:

(1) lenses used to balance an aphakic eyeglass lens; or

(2) recipient is blind in one eye and the visual acuity in the eye requiring

correction meets the diopter correction purchase criteria.

F. **Frames:** Medicaid covers frames for corrective lenses. Coverage for adults is limited to one frame in a twenty-four-month period.

G. **Contact lenses:** Medicaid covers contact lenses, either the original prescription or replacement, only with prior authorization. Coverage for adults is limited to one pair of contact lenses in a twenty-four-month period, unless an ophthalmologist or an optometrist recommends a change in prescription due to a medical condition affecting vision. Requests for prior authorization will be evaluated on dioptic criteria and/or visual acuity, the recipient's social or occupational need for contact lenses, and special medical needs. The criteria for authorization of contact lenses are as follows:

(1) the recipient must have a diagnosis of keratoconus or diopter correction of +/- -6.00 or higher in any meridian, at least 3.00 diopters of anisometropia.

(2) monocular aphakics may be provided with one contact lens and a pair of bifocal glasses.

H. **Replacement:** Eyeglasses or contact lenses that are lost, broken or have deteriorated to the point that, in the examiner's opinion, they have become unusable to the recipient, may be replaced for the following:

(1) recipients under twenty-one (21) years of age; or

(2) recipients twenty-one (21) years of age or older who have developmental disabilities.

(3) Documentation for replacement:

(a) the eyeglasses or contact lens (or lenses) must meet the diopter correction purchase criterion and must be recorded on the report of visual examination form; and

(b) the loss, deterioration or breakage must be documented in the appropriate section of the visual examination form.

[~~E.~~] I. **Prisms:** All prisms are covered if medically indicated to prevent diplopia (double vision). Documentation is required on the visual examination form.

[~~F.~~] J. **Lens tempering:** Medicaid covers lens tempering on new glass lenses only.

[~~G.~~] K. **Lens edging:** Medicaid covers lens edging and lens insertion.

[~~H.~~] L. **Minor repairs:** Medicaid covers minor repairs to eyeglasses.

[~~I.~~] M. **Dispensing fee:** Medicaid pays a dispensing fee to ophthalmologists, optometrists, or opticians for dispensing a combination of lenses and new frames. [~~The~~] This fee is not paid when contact lenses are dispensed.

[~~J.~~] N. **Eye prosthesis:** Medicaid covers eye prostheses (artificial eyes). Refer to 8.324.8 NMAC, *Prosthetics and Orthotics*.

[2/1/95; 8.310.6.12 NMAC - Rn, 8 NMAC 4.MAD.715.3 & A, 12/1/03; A, 7/1/04]

8.310.6.14 NONCOVERED SERVICES: Vision services are subject to the limitations and coverage restrictions that exist for other medicaid services. Providers must notify recipients of medicaid-covered and non-covered services by medicaid prior to providing services. If recipients choose to obtain non-covered services, they will be responsible for payment. See 8.301.3 NMAC, *General Noncovered Services* and 8.302.1 NMAC, *General Provider Policies*. Medicaid does not cover the following specific vision services:

A. orthoptic assessment and treatment;

B. photographic procedures, such as fundus or retinal photography and external ocular photography;

C. polycarbonate lenses other than for prescriptions for high-power lenses or monocular vision;

D. ultraviolet (UV) lenses;

E. trifocals;

F. progressive lenses;

[~~C.~~] G. tinted or photochromic lenses, except in cases of documented medical necessity. See [~~Paragraph (5) of Subsection B~~] Subsection D of 8.310.6.12 NMAC above [~~If a recipient desies tinted or photo-gray lenses, the recipient pay the difference between the cost of the tinted or photo-gray lenses and the cost of clear lenses~~];

[~~D.~~] H. [~~additional reimbursement for~~] oversize frames and oversize lenses; [~~the recipient pays the difference between the cost of the oversized frames and/or lenses and the cost of regular-sized frames and/or lenses;~~]

[~~E.~~] I. low vision aids;

[~~F.~~] J. eyeglass cases;

[~~G.~~] K. eyeglass or contact lens insurance; and

[~~H.~~] L. anti-scratch, anti-reflective, or mirror coating.

[2/1/95; 8.310.6.14 NMAC - Rn, 8 NMAC 4.MAD.715.5 & A, 12/1/03; A, 7/1/04]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.310.7 NMAC, Sections 12 and 13 which will be effective on July 1, 2004. The Medical Assistance Division amended the sections to remove the replacement of dental sealants on permanent premolar teeth; remove references to the prior authorization requirement for intravenous sedation and general anesthesia for adults; and eliminate nitrous oxide analgesia as a benefit for adult clients.

8.310.7.12 COVERED SERVICES AND SERVICE LIMITATIONS: Medicaid covers the following types of dental services with the specified limitations.

A. **Emergency services:** Medicaid covers emergency care for all eligible recipients. "Emergency" care is defined as services furnished when immediate treatment is required to control hemorrhage, relieve pain or eliminate acute infection [~~is required~~]. Care includes operative procedures necessary to prevent pulpal death and the imminent loss of teeth, and treatment of injuries to the teeth or supporting structures, such as bone or soft tissue contiguous to the teeth.

(1) Routine restorative procedures and root canal therapy are not emergency procedures.

(2) Prior approval requirements are waived for emergency care, but the claims can be reviewed prior to payment to confirm that an actual emergency existed at the time of service.

B. **Diagnostic services:** Medicaid coverage for diagnostic services is limited to the following:

(1) For recipients under twenty-one (21) years of age, diagnostic services are limited to one clinical oral examination every six (6) months. For recipients twenty-one (21) years of age and over, coverage is limited to one clinical oral examination per year; and

(2) Medicaid covers emergency oral examinations which are performed as part of an emergency service to relieve pain and suffering; and

C. **Radiology services**: Medicaid coverage of radiology services is limited to the following:

(1) One (1) intraoral complete series every three (3) years per recipient. This series includes bitewing x-rays. *Collaborative practice dental hygienists may provide this service.*

(2) Additional bitewing x-rays once every twelve (12) months per recipient. *Collaborative practice dental hygienists may provide this service.*

(3) Panoramic films performed can be substituted for an intraoral-complete series, which is limited to one every three (3) years per recipient. *Collaborative practice dental hygienists may provide this service.*

D. **Preventive services:** Medicaid coverage of preventive services is subject to certain limitations.

(1) **Prophylaxis:** Medicaid covers one prophylaxis service per recipient per provider every six (6) months for recipients under twenty-one (21) years of age. For recipients twenty-one (21) years of age or [~~over~~] older, medicaid covers one prophylaxis per recipient per year. *Collaborative practice dental hygienists may provide this service after diagnosis by a dentist.*

(2) **Fluoride treatment:** Medicaid covers one fluoride treatment per recipient per provider every six (6) months furnished in the office to recipients under twenty-one (21) years of age. For recipients twenty-one (21) years of age or [~~over~~] older, medicaid does not reimburse providers for fluoride treatments unless it is deemed medically necessary by MAD or its designee. *Collaborative practice dental hygienists may provide this service.*

(3) **Molar sealants:** Medicaid only covers sealants for permanent molars [~~and pre-molars~~] for recipients under twenty-one (21) years of age. Each eligible recipient can receive one treatment per tooth every five (5) years. Medicaid does not cover sealants when an occlusal restoration has been completed on the tooth. Replacement of a sealant within the five (5) -year periods requires prior approval. *Collaborative practice dental hygienists may provide this service after diagnosis by a dentist.*

(4) **Space maintenance:** Medicaid covers fixed unilateral and fixed bilateral space maintainers (passive appliances).

E. **Restorative services:** Medicaid covers the following restorative services:

(1) amalgam restorations (including polishing) on permanent and deciduous teeth;

(2) resin restorations for anterior and posterior teeth;

(3) one prefabricated stainless steel crown per permanent or deciduous tooth;

(4) one prefabricated resin crown per permanent or deciduous tooth; and

(5) one recementation of a crown or inlay.

F. **Endodontic services:** Medicaid covers therapeutic pulpotomy for recipients under twenty-one (21) years of age if performed on a primary or permanent tooth and no periapical lesion is present on a radiograph.

G. **Periodontic services:** Medicaid covers certain periodontics surgical, non-surgical and other periodontics services subject to certain limitations:

(1) collaborative practice dental [~~hygienist~~] hygienists may provide periodontal scaling and root planning, per quadrant after diagnosis by a dentist; and

(2) collaborative practice dental hygienists may provide periodontal maintenance procedures with prior authorization.

H. **Removable prosthodontic services:** Medicaid covers [~~only one denture adjustment~~] two denture adjustments per calendar year per recipient. Medicaid also covers repairs to complete and partial dentures.

I. **Fixed prosthodontics services:** Medicaid covers one recementation of a fixed bridge.

J. **Oral surgery services:** Medicaid covers the following oral surgery services:

(1) **simple and surgical extractions for all recipients:** Coverage includes local anesthesia and routine post-operative care; "erupted surgical extractions" are defined as extractions requiring elevation of mucoperiosteal flap and removal of bone, and/or section of tooth and closure.

(2) autogenous tooth reimplantation of a permanent tooth for recipients under twenty-one (21) years of age; and

(3) incision and drainage of an abscess for all recipients.

K. **Adjunctive general services:** Medicaid covers emergency palliative treatment of dental pain for all recipients. Medicaid covers general anesthesia and intravenous sedation for medicaid recipients [~~under twenty-one (21) years of age. For recipients twenty-one (21) years of age and over, prior approval is required for general anesthesia and intravenous sedation~~]. Documentation of medical necessity must be available for review by MAD or its designee. Medicaid covers nitrous oxide analgesia for [~~all~~] recipients under twenty-one (21) years of age.

[2/1/95; 8.310.7.12 NMAC - Rn, 8 NMAC 4.MAD.716.3 & A. 10/1/02; A, 7/1/04]

8.310.7.13 PRIOR APPROVAL AND UTILIZATION REVIEW: Dental services are subject to utilization review for medical necessity and program compliance. These reviews can be performed before services are furnished, after services are furnished and before payment is made, after payment is made, or at any point in the service or payment process. See Part 8.302.5 NMAC, *Prior Approval And Utilization Review*. Once enrolled, providers receive utilization review instructions and documentation forms which [~~assists~~] assist in the receipt of prior approval and claims processing.

A. **Prior approval:** Medicaid covers certain services, including some diagnostic, preventive, restorative, endodontic, periodontic, removable prosthodontics, maxillofacial prosthetic, oral surgery, and orthodontic services only when prior approval is received from MAD or its designee. Medicaid covers medically necessary orthodontic services to treat handicapping malocclusions for recipients under twenty-one (21) years of age with prior approval.

B. **Eligibility determination:** Prior approval of services does not guarantee that individuals are eligible for medicaid. Dental providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. **Reconsideration:** Providers [~~or recipients~~] who are dissatisfied with a utilization review decision or action can request a re-review and a reconsideration. See Part 8.350.2 NMAC, *Reconsideration Of Utilization Review Decisions*.

[2/1/95; 8.310.7.13 NMAC - Rn, 8 NMAC 4.MAD.716.4, 10/1/02; A, 7/1/04]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.311.3 NMAC, Section 12 which will be effective on July 1, 2004. The Medical Assistance Division amended the section to state that cost settlements will be based on a percentage of allowable amounts as approved by the Department, and that the GME payments may be decreased by a percentage approved by the Department.

8.311.3.12 PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS: Payment for all covered inpatient services rendered to Title XIX recipients admitted to acute care hospitals (other than those identified in [~~8.311.3.10 NMAC C. through E.~~)] Subsection C through E of 8.311.3.10 NMAC) on or after October 1, 1989 shall be made based on a prospective payment approach which compensates hospitals an amount per discharge for discharges classified according to the diagnosis related group (DRG) methodology. The prospective rates for each hospital's medicaid discharges will be determined by the department in the manner described in the following subsections.

A. **Services included in or excluded from the prospective payment rate:**

(1) Prospective payment rates shall constitute payment in full for each medicaid discharge. Hospitals may not separately bill the patient or the medicaid program for medical services rendered during an inpatient stay, except as described below. Hospitals may submit a claim for payment only upon the final discharge of a patient or

upon completion of the transfer of the patient to another acute care hospital.

(2) The prospective payment rate shall include all services provided to hospital inpatients[~~, including:~~]. These services shall include all items and non-physician services furnished directly or indirectly to hospital inpatients, [~~including but not limited to~~] such as:

(a) laboratory services;

(b) pacemakers and other prosthetic devices, including lenses and artificial limbs, knees and hips;

(c) radiology services, including computed tomography (CT) or magnetic resonance imaging (MRI) scans furnished to patients by a physician's office, other hospital or radiology clinic;

(d) transportation[~~,~~] (including transportation by ambulance)[~~,~~] to and from another hospital or freestanding facility to receive specialized diagnostic or therapeutic services.

(3) Services which may be billed separately include:

(a) ambulance service when the patient is transferred from one hospital to another and is admitted as an inpatient to the second hospital;

(b) physician services furnished to individual patients.

B. **Computation of DRG relative weights:**

(1) Relative weights used for determining rates for cases paid by DRG under the state plan shall be derived, to the greatest extent possible, from New Mexico medicaid hospital claim data. All such claims are included in the relative weight computation, except as described below.

(2) Hospital claim data for discharges occurring from January 1, 1985 through approximately the end of calendar year 1988 are included in the computation and prepared as follows:

(a) Claims are edited to merge interim bills from the same discharge.

(b) All medicaid inpatient discharges will be classified using the [~~Diagnostic Related Group (DRG)~~] DRG methodology, a patient classification system that reflects clinically cohesive groupings of inpatient cases which consume similar amounts of hospital resources. Claims are assigned to appropriate DRGs using version 6.0 of the health systems international DRG grouper software.

(c) Claims included in the computation of DRG relative weights were restricted to those claims for cases to be included in the proposed PPS. Claims for services provided in PPS-exempt hospitals or units (or for services otherwise exempt from the PPS) were not used to compute DRG relative weights.

(3) Charges for varying years are adjusted to represent a common year through application of inflation indices as described in [~~8.311.3.12.C(8) NMAC of this plan~~] Paragraph (8) of Subsection C of 8.311.3.12 NMAC.

(4) Initial relative weights are computed by calculation of the average medicaid charge for each DRG category divided by the average charge for all DRGs.

(5) Where the New Mexico medicaid-specific claims and charge data are insufficient to establish a stable relative weight, a relative weight is imported from other sources such as the CHAMPUS or medicare prospective payment systems. Weights obtained from external sources are normalized so that the overall case mix is 1.0.

(6) The relative weights computed as described above shall remain in effect until the next year. At that time, the relative weights will be recalculated using whatever DRG grouper version is currently in use by medicare.

C. **Computation of hospital prospective payment rates:**

(1) **Rebasing of rates:** Beginning October 1, 1997 the department [~~will discontinue~~] has discontinued the rebasing of rates every three years. Hospital rates in effect October 1, 1996 [~~will be~~] were updated by the most current market basket index (MBI) as determined by the centers for medicare and medicaid services (CMS) for rates effective October 1, 1997 and succeeding years. Thereafter, pursuant to budget availability and at the department's discretion, the application of the MBI inflation factor will be reviewed based upon economic conditions and trends. A notice will be sent out every October 1st, informing the provider whether the MBI will be used for the upcoming year and what the percentage increase will be if the MBI or a percentage up to the MBI is authorized to be applied.

(2) **Base year discharge and cost data:**

(a) The state's fiscal agent will provide the department with title XIX discharges for the provider's last fiscal year which falls in the calendar year prior to year 1.

(b) The state's audit agent will provide title XIX costs incurred, reported, audited, and/or desk audited for the same period.

(c) To calculate the total reimbursable inpatient operating costs from the cost and discharge data described above, the department will:

(i) exclude estimated outlier discharges and costs as described in [~~8.311.3.12.C(4) NMAC~~] Paragraph (4) of Subsection C of 8.311.3.12 NMAC of this part.

(ii) exclude pass-through costs, as identified in [~~Public Law 97-248~~] the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) provisions and further defined in [~~8.311.3.12.C(3)~~] Paragraph (3) of Subsection C of 8.311.3.12 NMAC below.

(3) **Definition of excludable costs per discharge; reduction of excludable capital costs:**

(a) The approach used by the department to define excludable costs parallels medicare's approach. Excludable costs are defined according to the PPS or TEFRA methodology and include such costs as those associated with capital, organ acquisition, and certified nurse anesthetists.

(b) The pass-through capital costs identified using TEFRA provisions will be reduced in a manner similar to that employed by the medicare PPS. For example, excludable capital costs for fiscal year 1989 will be reduced by 15 percent as required by Section 4006 of [~~Public Law 100-203 (Omnibus~~] the Omnibus Budget Reconciliation Act of 1987. However, any such reduction to pass-through capital costs will only apply to those costs incurred after October 1, 1989.

(4) **Outlier adjustment factors:** Hospital-specific outlier adjustment factors will be used to deduct outlier costs and cases from the total medicaid inpatient operating costs and cases used in rate setting. These factors will be determined by using actual claim and cost data for outlier cases for the base year period. Only claims for cases to be paid by DRG will be included in the analysis used to determine this estimate. The definition of an outlier case can be found in [~~8.311.3.12.F(1) NMAC~~] Paragraph (1) of Subsection F of 8.311.3.12 NMAC of this part.

(5) **Calculation of base year operating cost per discharge:** The total reimbursable inpatient operating cost (excluding pass-through costs and estimated outlier costs) is divided by the hospital's number of non-outlier medicaid discharges to produce the base year operating cost per discharge. The base rate methodology is described below:

$$BYOR = \frac{OC}{D}$$

BYOR = base year operating cost per discharge

OC = total Title XIX inpatient operating cost for the base year, less excludable costs and estimated outlier costs

D = medicaid discharges for the hospital's base year as provided by the department's fiscal agent, less estimated outlier cases.

(6) **Possible use of interim base year operating cost per discharge rate:**

(a) If the fiscal agent and audit agent have not provided the department with a hospital's base year discharges and costs as of June 1 prior to year 1, the department will develop an interim operating cost per discharge base rate. This rate will be developed according to the normal base rate methodology, but using costs and discharges for the fiscal year prior to the base year.

(b) When an interim rate is developed, the operating costs per discharge are first multiplied by an inflation index (as described in [~~8.311.3.12.C(8) NMAC of this plan)~~] Paragraph (8) of Subsection C of 8.311.3.12 NMAC of this part to bring the costs to the midpoint of the base year. When the provider's actual base year costs and discharges become available, the department will calculate a final base year operating cost per discharge using the normal base rate methodology. The rate that is computed from the final base year operating costs per discharge will apply to all discharges in year 1, retroactive to the effective date of the interim rate.

(7) **Prohibition against substitution or rearrangement of base year cost reports:**

(a) A hospital's base year cost reports cannot be substituted or rearranged once the department has determined that the actual cost submission is suitable. A submission shall be deemed suitable 180 days from the date of the notice of proposed rate (NPR) issued by the state's intermediary in the absence of an appeal by the hospital to the intermediary and the state.

(b) In the event of such an appeal, the state must make a written determination on the merits of the appeal within 180 days of receipt, although the state may make a determination to extend such period to a specified date as necessary. Once such an appeal has been determined, the resulting base cost will be effective retroactively to year 1 and will not be changed until subsequent rebasing of all hospitals has been completed.

(8) **Application of inflation factors:**

(a) The inflation factors used to update operating costs per discharge will be identical to those established by congress and adopted for use by the [~~Health Care Financing Administration (HCFA)~~] centers for medicaid and medicare services (CMS) to update medicare inpatient prospective payment rates. The medicare prospective payment update factor (MPPUF) is determined by [~~HCFA~~] CMS, usually on an annual basis, and may differ depending upon the hospital type (urban, large urban, or rural) as defined by [~~HCFA~~] CMS.

(b) Each hospital's base year operating cost per discharge will be indexed up to the common point of December 31 falling prior to year 1, using the applicable medicare prospective payment update factors (MPPUF) for that hospital for that period. That is, the inflation factors used will be identical to those established by congress and adopted for use by [~~HCFA~~] CMS to update medicare inpatient prospective payment rates, including any established differential for urban and rural hospitals. Then this value will be indexed using the applicable MPPUF corresponding to the period beginning October 1 (prior to year 1) and ending with the midpoint of operating year 1. For years 2 and 3, the inflation factors will be the applicable MPPUF as specified by [~~HCFA~~] CMS.

(c) For the period October 9, 1991, through September 30, 1992, an exception to (a) and (b) above [~~will be~~] was made. The inflation factor used to update rates for that period [~~will be~~] is .5% for urban hospitals and 1.5% for rural hospitals.

(9) **Case-mix adjustments for base year operating cost per discharge rate:**

(a) The department will adjust the operating cost per discharge rate to account for case-mix changes, based on the classification of inpatient hospital discharges according to the [~~Diagnostic Related Group (DRG)~~] DRG methodology established and used by the medicare program.

(b) For each DRG, the department determines a relative value (the DRG relative weight) which reflects the charges for hospital resources used for the DRG relative to the average charges of all hospital cases. The department's methodology for computing DRG relative weights was discussed earlier in [~~8.311.3.12.B NMAC~~] Subsection B of 8.311.3.12 NMAC. Case-mix adjustments will be computed using the methodology described below:

(c) **Case-mix computation:** Each base year, a hospital's case-mix index will be computed by the department and its fiscal agent as follows:

(i) All title XIX discharges are assigned to appropriate DRGs.

(ii) The case-mix index is computed for each hospital by summing the products of the case frequency and its DRG weight and dividing this sum by the total number of title XIX cases at the hospital.

(d) The case-mix adjustment is applied to the base year operating cost per discharge as described in [~~8.311.3.12.C(10)(e) NMAC~~] Subparagraph (e) of Paragraph (10) of Subsection C of 8.311.3.12 NMAC below.

(10) **Limitations on operating cost prospective per discharge rates:**

(a) Limitations on operating cost prospective base rates will be imposed using a peer group methodology. Effective October 1, 1989, hospitals will be placed in one of six possible peer groups (teaching, referral, regional, low-volume regional, community and low-volume community) based on the following criteria: bed size, case-mix, services available, population served, location, trauma designation, teaching status, and low-volume (i.e. less than 150 medicaid discharges per year.)

(b) At the time of the next rebasing year following October 1, 1989, the criteria regarding low-volume [~~will be~~] utilization was dropped along with the low-volume peer groups, thus leaving four possible peer groups for assignment. (teaching, referral, regional and community).

(c) The department will determine the peer group assignment of each hospital, and appeal of such assignment will be allowed only as described in [~~8.311.3.12.D(1) NMAC~~] Paragraph (1) of Subsection D of 8.311.3.12 NMAC of this part.

(d) A ceiling on allowable operating costs will be set at 110 percent of the median of costs for all hospitals in the peer group, after application of each hospital's case mix and indexing of the cost from the hospital's fiscal year end to a common point of December 31. These adjustments are made to equalize the status of each hospital for ceiling establishment purposes. The median shall be the midpoint of rates (or the average of the rates of the two hospitals closest to the midpoint).

(e) The case-mix equalization for each hospital in a peer group will be calculated as follows:

PGR = BYOR/CMI

PGR = hospital rate equalized for peer group comparison

BYOR = base year operating cost per discharge

CMI = case-mix index in the base year

(f) The allowable operating cost per discharge rate (hospital-specific rate) will be the lower of:

(i) the ceiling for the hospital's peer group; or

(ii) the hospital rate resulting from the computation found in [~~8.311.3.12.C(10)(e) NMAC~~] Subparagraph (e) of Paragraph (10) of Subsection C of 8.311.3.12 NMAC above.

(11) **Computation of prospective operating cost per discharge rate:** The following formulas are used to determine the prospective operating cost per discharge rate for years 1, 2, and 3:

Year 1

PD01 = HSR x (1 + MPPUF)

PD01 = per discharge operating cost rate for year 1

HSR = the hospital-specific

rate, which is the lower of the peer group ceiling or the hospital's rate, equalized for peer group comparison

MPPUF = the applicable medicare prospective payment update factor as described in [~~8.311.3.12.C.(8) NMAC~~] Paragraph (8)of Subsection C of 8.311.3.12 NMAC.

Year 2

PDO2 = PDO1 x (1 + MPPUF)

PDO2 = per discharge operating cost rate for year 2

PDO1 = per discharge operating cost rate for year 1

MPPUF = the applicable medicare prospective payment update factor as described in [~~8.311.3.12.C.(8) NMAC~~] Paragraph (8)of Subsection C of 8.311.3.12 NMAC.

Year 3

PDO3 = PDO2 x (1 + MPPUF)

PDO3 = per discharge operating cost rate for year 3

PDO2 = per discharge operating cost rate for year 2

MPPUF = the applicable medicare prospective payment update factor as described in [~~8.311.3.12.C.(8) NMAC~~] Paragraph (8)of Subsection C of 8.311.3.12 NMAC.

(12) **Computation of excludable cost per discharge rate:** Total medicaid excludable cost, as identified in [~~Public Law 97-248 (TEFRA)~~] TEFRA, with excludable capital costs reduced as indicated in [~~8.311.3.12.C.(3) NMAC~~] Paragraph (3)of Subsection C of 8.311.3.12 NMAC, will be paid in the following manner:

(a) An excludable cost per discharge rate is computed using the following methodology:

ER = ECP/DCY

ER = excludable cost per discharge rate

ECP = excludable costs on the hospital's most recently settled cost report prior to the rate year, as determined by the audit agent

DCY = medicaid discharges for the calendar year prior to the rate year, as determined by the department's fiscal agent

(b) The retrospective settlement will be determined based on a percentage of the actual allowable amount of medicaid excludable costs incurred by a hospital during the hospital's fiscal year as determined by the department.

(13) **Computation of prospective per discharge rate:** The excludable cost per discharge, as described in [~~8.311.3.12.C(12) NMAC~~] Paragraph (12) of Subsection C of 8.311.3.12 NMAC above, will be added to the appropriate operating per discharge rates to determine the prospective rates.

(14) **Effective dates of prospective rates:** Rates [~~will be effective for implementation~~] were implemented October 1, 1989 and continue to be effective [~~thereafter~~] as of October 1 of each year for each hospital.

(15) **Effect on prospective payment rates of a change of hospital ownership:** When a hospital is sold or leased, no change is made to the hospital's per discharge rate as a result of the sale or lease transaction.

(16) **Rate setting for border-area hospitals:** Border-area hospitals will be reimbursed at median rate (including excludable cost pass-throughs) for the regional peer group.

D. **Changes to prospective rates:**

(1) **Appeals:** Hospitals may appeal for a change in the operating component of the prospective payment rate, including a change in peer group assignment, as applicable. For an appeal to be considered, the hospital must demonstrate in the appeal that:

(a) the following five requirements are satisfied:

(i) the hospital inpatient service mix for medicaid admissions has changed due to a major change in scope of facilities and services provided by the hospital;

(ii) the change in scope of facilities and services has satisfied all regulatory and statutory requirements which may be applicable, such as facility licensure and certification requirements and any other facility or services requirements which might apply;

(iii) the expanded services were a) not available to medicaid patients in the area or b) are now provided to medicaid patients by the hospital at a lower reimbursement rate than would be obtained in other hospitals providing the service;

(iv) the magnitude of the proposed (as appealed) prospective per discharge rate for the subsequent year will exceed 105 percent of the rate that would have otherwise been paid to the hospital;

(v) in addition to requirements (i) through (iv) above, appeals for rate adjustment will not be considered if cost changes are due to changes in hospital occupancy rate, collective bargaining actions, changes in hospital ownership or affiliation, or changes in levels of rates of increases of incurred cost items which were included in the base rate.

(b) the appeal must provide a specific recommendation(s) regarding the magnitude of alterations in the appellant's prospective rate per discharge and peer group reassignment, as applicable. In making its decision on any appeal, the department shall be limited to the following options:

(i) reject the appeal on the basis of a failure of the appellant to demonstrate necessary conditions and documentation for an appeal as specified in [~~8.311.3.12.D(1)(a)~~] Subparagraph (a) of Paragraph (1) of Subsection D of 8.311.3.12 NMAC above; or

(ii) accept all of the specific recommendations, as stated in the appeal, in their entirety; or

(iii) adopt modified versions of the recommendations as stated in the appeal; or

(iv) reject all of the recommendations in the appeal.

(c) hospitals are limited to one appeal per year, which must be filed in writing with the medical assistance division director by a duly authorized officer of the hospital no later than July 1 of each year; within 15 calendar days of the filing date, the department shall offer the appellant the opportunity for hearing of the appeal; if such a hearing is requested, it shall occur within 30 days of the filing date; the department shall notify the appellant of the decision of the appeal in writing no later than September 15 of the year in which the appeal is filed.

E. **Retroactive settlement:**

(1) Retroactive settlement may occur in those cases in which no audited cost reports were available at the time of rate setting and an interim rate was used. Retroactive settlement will only occur in those cases where adjustments to interim rates are required. For year 1, the department's audit agent will determine the difference between payments to the hospital under the interim operating cost per discharge rate and what these payments would have been under the final rate. The audit agent will report the amount of overpayment or underpayment for each facility within 90 days of the effective date of the final rate. Retroactive settlements will be based on actual claims paid while the interim rate was in effect.

(2) **Underpayments:** In the event that the interim rate for year 1 is less than the final rate, the department will include the amount of underpayment in a subsequent payment to the facility within 30 days of notification of underpayment.

(3) **Overpayments:** In the event that the interim rate exceeds the final rate, the following procedure will be implemented: the facility will have 30 days from the date of notification of overpayment to submit the amount owed to the department in full. If the amount is not submitted on a timely basis, the department will begin

withholding from future payments until the overpayment is satisfied in full.

(4) Retroactive settlements for excludable costs will be handled in the same manner as described above.

F. **Special prospective payment provisions:**

(1) **Outlier cases:**

(a) Effective for discharges occurring on or after April 1, 1992, outlier cases are defined as those cases with medically necessary services exceeding $100,000 in billed charges, or those with medically necessary lengths of stay of 75 days or more, when such services are provided to children up to age six in disproportionate share hospitals, and to infants under age one in all hospitals. These cases will be removed from the DRG payment system and paid at an amount equal to 90% of the hospital's standardized cost. Standardized costs are determined by multiplying the hospital's allowable billed charges by the hospital's cost-to-charge ratio as calculated from the hospital's most recent cost report.

(b) Utilization review will be performed on all outlier cases to determine the medical necessity of services rendered. Should this review determine non-medical necessity for all or part of the services, these services will be deducted from the billed amount prior to payment.

(2) **Payment for transfer cases:**

(a) All cases transferred from one acute care hospital to another will be monitored under a utilization review policy to ensure that the department does not pay for inappropriate transfers.

(b) The following methodology will be used to reimburse the transferring and discharging hospitals for appropriate transfers if both hospitals and any hospital units involved are included in the PPS.

(i) A hospital inpatient shall be considered "transferred" when he or she has been moved from one acute inpatient facility to another acute inpatient facility. Movement of a patient from one unit to another unit within the same hospital shall not constitute a transfer, unless the patient is being moved to a PPS exempt unit within the hospital.

(ii) The transferring hospital will be paid the lesser of standardized costs or the appropriate DRG payment amount. Should the stay in the transferring hospital qualify for an outlier payment, then the case will be paid as an outlier as described in [~~8.311.3.12.F. NMAC of this plan~~] Subsection F of 8.311.3.12 NMAC of this part. Standardized costs are determined by multiplying the hospital's allowable billed charges by the hospital's cost-to-charge ratio.

(iii) The receiving hospital which ultimately discharges the patient will receive the full DRG payment amount, or, if applicable, any outlier payments associated with the case. All other hospitals which admitted and subsequently transferred the patient to another acute care hospital during a single spell of illness shall be considered transferring hospitals.

(c) If the transferring or discharge hospital or unit is exempt from the PPS, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or unit.

(3) **Payment for readmissions:** Readmissions occurring within 15 days of prior acute care admission for a related condition will be reviewed to determine medical necessity and appropriateness of care. If it is determined that either or both admissions were unnecessary or inappropriate, payment for either or both admissions may be denied. Such review may be focused to exempt certain cases at the sole discretion of the department.

(4) **Payment for inappropriate brief admissions:** Hospital stays of up to two days in length will be reviewed for medical necessity and appropriateness of care. (Discharges involving healthy mothers and healthy newborns are excluded from this review requirement.) If it is determined that the inpatient stay was unnecessary or inappropriate, the prospective payment for the inpatient discharge will be denied. If the inpatient claim is denied, the hospital is permitted to resubmit an outpatient claim for the services rendered. Such review may be further focused to exempt certain cases at the sole discretion of the department.

(5) **Payment for non-medically warranted days:**

(a) Reimbursement for hospital patients receiving services at an inappropriate level of care will be made at rates reflecting the level of care actually received. The number of days covered by the medicaid program is determined based only upon medical necessity for an acute level of hospital care.

(b) When it is determined that an individual no longer requires acute-level care but does require a lower level of institutional care, and when placement in such care cannot be located, the hospital will be reimbursed for "awaiting placement" days. Reimbursement will be made at the weighted average rate paid by the department in the preceding calendar year for the level of care needed. There is no limit on the number of covered "awaiting placement" days as long as those days are medically necessary. However, the hospital is encouraged to make every effort to secure appropriate placement for the individual as soon as possible. During "awaiting placement" days, no ancillary services will be paid, but medically necessary physician visits will be reimbursed.

(6) **Sole community hospital payment adjustment:** Effective for the quarter beginning July 1, 1993, in-state care hospitals that qualify as sole community hospitals are entitled to receive a sole community hospital payment adjustment in accordance with the provisions specified below:

(a) To qualify for a sole community hospital payment adjustment, an acute care hospital must meet the medicare classification criteria for a sole community hospital as set forth at 42 CFR 412.92. The hospital must qualify for a sole community hospital designation in the month prior to the effective date for the sole community adjustment. If a hospital already has a sole community hospital designation from medicare this designation will be accepted by the medicaid program. If for some reason, the hospital elected not to apply for sole community hospital designation under medicare but wished to apply for medicaid purposes only, such application must be made directly to the medicaid program. The medicaid program will review the application in accordance with the criteria contained at 42 CFR 412.92.

(b) For an in-state acute care hospital that qualifies as a sole community hospital in accordance with paragraph (6)(a) above, the department will make a quarterly sole community hospital payment at the end of each quarter. For the initial payment year (July 1, 1993, through June 30, 1994), the payment is the amount specified under paragraph (6)(c) below. For subsequent years, the amount will be the amount calculated under paragraph (6)(d) through (6)(f) below.

(c) For the initial payment year, the sole community hospital payment amount will be equal to the amount the hospital received from county government, either through the County Indigent Claims Act or by mill levy revenues dedicated to supporting the hospital's operating expenses, for calendar year 1992 (the base year) plus the inflation factor described in [~~8.311.3.12.C(8) NMAC~~] Paragraph (8) of Subsection C of 8.311.3.12 NMAC of this part. Verification of the base year amount will be made from the official report of expenditures by each county. Hospital will have the opportunity to challenge the amount by filing an appeal with the department within 30 days from the date they receive notice from the state of their sole community payment amount. If the hospital qualifies for the sole community designation later than the effective date of the plan amendment, the medicaid program will prorate the sole community payment adjustment for the first quarter from the date of qualification to the end of that quarter.

(d) For each subsequent plan year, the sole community hospital is required to submit to the department, no later than January 15 for the subsequent state fiscal year, a sole community hospital payment request. If the hospital cannot meet the January 15 deadline, the hospital may submit a written request for up to 30-day extension. Such requests must be received prior to the January 15 deadline.

(e) The sole community provider payment request must be reviewed and approved by the county government in which the hospital is located. In order for the request to be valid, the county government's approval must be submitted with the hospital's request. If the hospital does not submit a valid request within the time frame identified above, it will not be eligible for a sole community provider adjustment for that year regardless of the hospital's status as a sole community hospital.

(f) For years subsequent to the initial payment year, the sole community hospital payment adjustment will be the lessor of the amount paid by the department for the previous year trended forward. The department will use the market basket forecast published periodically in the [~~HCFA~~] CMS regional medical services letter, or an amount mutually agreed upon by the hospital and the county government.

(g) The department will calculate the medicare payment limit (specified at 42 CFR 447) annually. If the upper limit has not been exceeded, additional payments will be distributed by the department. Should the amounts requested from the hospitals exceed the amount available under the upper limit, the amounts will be prorated and distributed based on the amount of the request received by the department.

(7) **State-operated teaching hospital adjustment:** Teaching hospitals (as defined in section 4.19-(A)(III)(F)(8)(a) of the state plan operated by the state of New Mexico or an agency thereof, shall qualify for an inpatient state operated teaching hospital rate adjustment. The adjustment shall result in total payments to the hospitals that are equal to but not in excess of the individual facility's medicare-related upper payment limit (specified at 42 CFR 447.272). The department will calculate the medicare upper payment limit for state-operated teaching hospitals annually. If the upper payment limit has not been exceeded, additional payments will be distributed by the department to the state-operated teaching hospital. The adjustment shall be calculated as follows:

(a) Each federal fiscal year, the department shall determine each state-operated teaching hospital's medicare per discharge rate and medicaid per discharge rate. The medicare and/or medicaid discharge rate will be adjusted to reflect any acuity differences that exist between the medicare and medicaid patients served. Acuity differences will be determined from the medicare and medicaid case-mix indices (CMI) for medicaid discharges at the hospital using medicare and medicaid DRG weights in effect at the time (using data from the most recent state fiscal year for which complete data is available).

(b) The medicaid per discharge rate shall be subtracted from the medicare per discharge rate.

(c) The difference shall be multiplied by the number of medicaid discharges at the hospital for the most recent state fiscal year. The result shall be the amount of the state-operated teaching hospital adjustment for the current federal fiscal year.

(d) For federal fiscal year 2000, and subsequent federal fiscal years, payment shall be made on an annual basis before the end of the federal fiscal year.

(e) In the event that the state-operated teaching adjustment amount exceeds the medicare-related upper payment limit for that year, the state-operated teaching hospital adjustment will be revised by the difference.

(8) **Indirect medical education (IME) adjustment:** Effective August 1, 1992, each acute care hospital that [~~qualify as~~] qualifies as a teaching hospital will receive an indirect medical education (IME) payment adjustment, which covers the increase operating or patient care costs that are associated with approved intern and resident programs.

(a) In order to qualify as a teaching hospital and be deemed eligible for an IME adjustment, the hospital must:

(i) be licensed by the state of New Mexico; and

(ii) be reimbursed on a DRG basis under the plan; and

(iii) have 125 or more full-time equivalent (FTE) residents enrolled in approved teaching programs.

(b) Determination of a hospital's [~~eligible~~] eligibility for an IME adjustment will be done annually by the [~~state~~] department, as of the first day of the provider's fiscal year. If a hospital meets the qualification for an IME adjustment after the start of its fiscal year, it will be deemed eligible for the IME adjustment beginning on the first day of the quarter after the date the qualification were met.

(c) The IME payment amount is determined by multiplying DRG operating payments, which are DRG payments and outlier payments, by the IME adjustment factor computed by the following formula:

$$1.89+((1+R)^{.405}-1$$

where R equals the number of approved full-time equivalent residents divided by the number of available beds (excluding nursery and neonatal bassinets). Full-time equivalent residents are counted in accordance with 42 CFR 412.105(f). For purposes of this paragraph, DRG operating payments include the estimated average per discharge amount that would otherwise have been paid for medicaid managed care enrollees if those persons had not been enrolled in managed care.

(d) Quarterly IME payments will be made to qualifying hospital at the end of each quarter. Prior to the end of each quarter, the provider will submit to the department's audit agent the information necessary to make the calculation, i.e. number of beds, number of estimated residents for the quarter, and the medicaid DRG amount. After review and adjustment, if necessary, the audit agent will notify the department of the amount due to/from the provider for the application quarter. Final settlement of the IME adjustment amount will be made through the cost report; that is, the number of beds, residents, and DRG amounts used in the quarterly calculation will be adjusted to the actual numbers shown on the provider's cost report for those quarters.

(9) **Payment for direct graduate medical education (GME):** Effective for services provided on or after July 1, 1998, payment to hospitals for GME expense is made on a prospective basis as described in this section. Payments will be made quarterly to qualifying hospitals, at a rate determined by the number of resident full-time-equivalents (FTEs) in the various categories defined below, who worked at the hospital during the preceding year, and subject to an upper limit on total payments.

(a) To be counted for medicaid reimbursement, a resident must be participating in an approved residency program, as defined by medicare in 42 CFR 413.86. With [~~regards~~] regard to categorizing residents, as described in paragraph (9)(b) below, the manner of counting and weighting resident FTEs will be the same as is used by medicare in 42 CFR 413.86. Resident FTEs whose costs will be reimbursed by the department as a medical expense to a federally qualified health center are not eligible for reimbursement under this section. To qualify for medicaid GME payments, a hospital must be licensed by the state of New Mexico, be currently enrolled as a medicaid provider, and must have achieved a medicaid inpatient utilization rate of 5% or greater during its most recently concluded hospital fiscal year. For the purposes of this section, the medicaid inpatient utilization rate will be calculated as the ratio of New Mexico medicaid eligible days, including inpatient days paid under medicaid managed care arrangements, to total inpatient hospital days.

(b) Approved resident FTEs are categorized as follows for medicaid GME payment:

(i) **Primary care/obstetrics resident.** Primary care is defined per 42 CFR 413.86(b).

(ii) **Rural health resident.** A resident participating in a designated rural health residency program. Residents enrolled in a designated rural health residency program will be counted as a rural health resident FTE for the entire duration of their residency, including those portions of their residency which may be served in a non-rural hospital or clinic. Should any resident meet the criteria for both rural health and primary care in this section, this resident will be counted as a rural health resident.

(iii) **Other approved resident.** Any resident not meeting the criteria [~~for categories~~] in subparagraphs (i) or (ii), above.

(c) **Medicaid GME payment amount per resident FTE:**

(i) The annual medicaid payment amount per resident FTE for state fiscal year 1999 is as follows:

Primary care/obstetrics resident:	$22,000
Rural health resident:	$25,000
Other resident:	$21,000

(ii) The per resident amounts specified in [~~8.311.3.12.F.(9)(c)(i) NMAC~~] Item (i) of Subparagraph (c) of Paragraph (9) of Subsection F of 8.311.3.12 NMAC will be inflated for state fiscal years beginning on or after July 1, 1999 using the annual inflation update factor described in [~~8.311.3.12.F(9)(d)(ii) NMAC~~] Item (ii) of Subparagraph (d) of Paragraph (9) of Subsection F of 8.311.3.12 NMAC.

(d) **Annual inflation update factor:**

(i) Effective for state fiscal years 2000 and beyond, the department [~~will update~~] has updated the per resident GME amounts and the upper limit on GME payments for inflation, using the market basket forecast published in the [~~HCFA~~] CMS Dallas regional medical services letter issued for the quarter ending in March 1999 to determine the GME rates for state fiscal year 2000 (July 1, 1999 - June 30, 2000).

(ii) The department will use the market basket forecast shown for PPS hospitals that is applicable to the period during which the rates will be in effect. [~~For example, the Department will use the forecast shown for July 1, 1999 - June 30, 2000 to update the rates for state fiscal year 2000.~~] The medical assistance division will determine the percentage of funds available for GME payments to eligible hospitals.

(e) **Annual upper limits on GME payments:**

(i) Total annual medicaid GME payments will be limited to $5,800,000 for state fiscal year 1999. This amount will be updated for inflation, beginning with state fiscal year 2000, in accordance with [~~paragraph 8.311.3.12.F(9)(d) NMAC.~~] Subparagraph (d) of Paragraph (9) of Subsection F of 8.311.3.12 NMAC:

(ii) Total annual GME payments for residents in Category B.3, "Other," will be limited to the following percentages of the $5,800,000 total annual limit (as updated for inflation in accordance with [~~8.311.3.12.F.(9)(d) NMAC~~] Subparagraph (d) of Paragraph (9) of Subsection F of 8.311.3.12 NMAC).

state fiscal year 1999	58.3%
state fiscal year 2000	56.8%
state fiscal year 2001	53.3%
state fiscal year 2002	50.7%
state fiscal year 2003	48.0%
state fiscal year 2004	45.5%
state fiscal year 2005	43.0%
state fiscal year 2006	40.4%

(f) **Reporting and payment schedule:**

(i) Hospitals will count the number of residents working according to the specification in this part during each fiscal year (July 1 through June 30) and will report this information to the department by December 31. Counts will represent the weighted average number of residents who worked in the hospitals during the specified 12-month period. Hospitals may also add to this count any FTEs associated with newly approved residency programs that will be implemented on or before the start of the prospective GME payment year, to the extent that these FTEs are not already reflected in the weighted average counts of the preceding year. To illustrate, resident FTE amounts would be counted from 07/01/96 - 06/30/97 for the payment year 07/01/98 - 06/30/99. The department may require hospitals to provide documentation necessary to support the summary counts provided.

(ii) The department will establish the amount payable to each hospital for the prospective payment period that will begin each July 1. Should total payments as initially calculated exceed either of the limitations in [~~8.311.3.12.D. NMAC~~] Subsection D of 8.311.3.12 NMAC, the amount payable to each will be proportionately reduced.

(iii) The annual amount payable to each hospital is divided into four equal payments. These payments will be made by the department on or about the start of each prospective payment quarter.

(iv) Should a facility not report timely with the accurate resident information as required in [~~8.311.3.12.F.(9)(f)(i) NMAC~~] Item (i) of Subparagraph (f) of Paragraph (9) of Subsection F of 8.311.3.12 NMAC above, it will still be entitled to receive payment for any quarter yet remaining in the prospective payment year, after acceptable information has been submitted. However, payments to untimely reporting facilities will be limited to the amount of funds that remain available under the upper limits described in [~~8.311.3.12.D. NMAC~~] Subsection D of 8.311.3.12 NMAC, after prospective payment amounts to timely filing facilities have been established.

[2-1-95, 10-31-97, 6-30-98, 9-1-98, 1-1-99, 8.311.3.12 NMAC - Rn, 8 NMAC 4.MAD.721.D.III & A, 1-1-01; A, 10-1-02; A, 7-1-04]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.232.600 NMAC, Sections 12, 13 and 14 which will be effective on July 1, 2004. The Medical Assistance Division amended the sections to reflect other changes due to the change in the redetermination period. This rule was also renumbered and reformatted from 8 NMAC 4.KID.600 to comply with NMAC requirements.

8.232.600.12 ONGOING BENEFITS: Periodic reviews are conducted [~~on a yearly basis~~] every six (6) months.

[2/1/95; 8.232.600.12 NMAC - Rn, 8 NMAC 4.KID.624 & A, 7/1/04]

8.232.600.13 RETROACTIVE BENEFIT COVERAGE: Up to three (3) months of retroactive medicaid coverage can be furnished to applicants/recipients who have received medicaid-covered services during the retroactive period and would have met applicable eligibility criteria had they applied during the three (3) months prior to the month of application [42 CFR Section 435.914]. [~~Prior to April 1, 1995, no retroactive medicaid coverage is available for applicants/recipients who did not meet all applicable eligibility criteria in effect as of March 31, 1995.~~]

A. **Application for retroactive benefit coverage:** Application for retroactive medicaid can be made by checking "yes" to the question "does anyone in your household have unpaid medical expenses in the last three (3) months?" on the application for assistance (ISD 100 S) form or by checking "yes" to the question "does anyone have any unpaid medical bills from the past three months?" on the application for medical assistance for children and pregnant women (MAD 023) form. Applications for retroactive medicaid benefits must be made [~~by~~] no later than 180 days from the date of application for assis-

tance. Medicaid-covered services which were furnished more than two (2) years prior to application are not covered.

B. **Approval requirements:** To establish retroactive eligibility, the [~~ISS~~] income support division worker must verify that all conditions of eligibility were met for each of the three (3) retroactive months and that the applicant received medicaid-covered services. Each month must be approved or denied on its own merits. Retroactive eligibility can be approved on either the ISD2 system or on the retroactive medicaid eligibility authorization (ISD 333) form.

C. **Notice:**

(1) **Notice to applicant:** [~~The applicant must be informed if any of the retroactive months are denied.~~] The income support division worker must inform the applicant if any of the retroactive months are denied.

(2) Recipient responsibility to notify provider: After the retroactive eligibility has been established, the [~~ISS~~] income support division worker must notify the recipient that he/she is responsible for informing all providers with outstanding bills of the retroactive eligibility determination. If the recipient does not inform all providers and furnish verification of eligibility which can be used for billing and the provider consequently does not submit the billing within 120 days from the date of approval of retroactive coverage, the recipient is responsible for payment of the bill.

[2/1/95; 4/1/95; 7/1/95; 8.232.600.13 NMAC - Rn, 8 NMAC 4.KID.625 & A, 7/1/04]

8.232.600.14 CHANGES IN ELIGIBILITY:

A. **Eligibility termination when age limit reached:** If a recipient's eligibility ends because he/she turns nineteen (19) years of age and the recipient is receiving inpatient services in an acute care hospital on the date he/she turns nineteen (19) years of age, the recipient's eligibility continues until the end of that admission. If the recipient is an inpatient in a free-standing psychiatric facility or other residential facility, the recipient's eligibility continues until the end of the month in which the recipient turns nineteen (19) years of age. The [~~ISS~~] income support division worker verifies that the closure is caused by the recipient's turning nineteen (19) years of age and terminates medicaid eligibility at the end of the applicable time period.

B. [~~**Continuous 12 month eligibility:** A recipient who is initially eligible under category 032 who would lose eligibility because of a change in family income remains eligible under category 032 for the twelve (12) months, starting with the first month of eligibility. This provision applies even if the family income exceeds the federal poverty income guidelines. The 12 month continuance is separate from any months of presumptive or retroactive eligibility.~~] **Ongoing eligibility:** A redetermination of eligibility is made every six (6) months. All changes that may affect eligibility must be reported within ten (10) days of the date of the change. Changes in eligibility status will be effective the first day of the following month.

[2/1/95; 4/1/95; 6/30/98; 8.232.600.14 NMAC - Rn, 8 NMAC 4.KID.630 & A, 7/1/04]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.324.5 NMAC, Sections 10 through 16, which will be effective on July 1, 2004. The Medical Assistance Division amended the sections to show program changes to the Durable Medical Equipment and Medical Supplies program. This rule was also renumbered and reformatted from 8 NMAC 4.MAD.754 to comply with NMAC requirements.

8.324.5.10 ELIGIBLE PROVIDERS: Upon approval of medical assistance program provider participation agreements by the medical assistance division (MAD), all suppliers of medical supplies and/or durable medical equipment [~~which~~] that are licensed to do business may become medicaid providers. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as they receive new materials [~~are received~~] from MAD.

[2/1/95; 8.324.5.10 NMAC - Rn, 8 NMAC 4.MAD.754.1 & A, 7/1/04]

8.324.5.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records [~~which~~] that are sufficient to fully disclose the extent and nature of the services provided to recipients. See 8.302.1 NMAC, *General Provider Policies*. Providers must notify recipients of covered and non-covered services by medicaid prior to providing services. See 8.301.3 NMAC, *General Noncovered Services* and 8.302.1 NMAC, *General Provider Policies*.

[2/1/95; 8.324.5.11 NMAC - Rn, 8 NMAC 4.MAD.754.2 & A, 7/1/04]

8.324.5.12 COVERED DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES:

A. Medicaid covers durable medical equipment (DME) [~~which~~] that meet the definition of DME, the medical necessity criteria and the prior [~~approval~~] authorization requirements. Medicaid covers repairs, maintenance, delivery of durable medical equipment and disposable and non-reusable items essential for use of the equipment, subject to the limitations specified in this section. All items purchased or rented must be ordered by providers who are [~~eligible to participate in Medicaid~~] currently enrolled in medicaid.

(1) "Durable medical equipment" is defined as equipment [~~which~~] that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not useful to individuals in the absence of an illness or injury and is appropriate for use at home.

(2) Equipment used in a recipient's residence must be used exclusively by the recipient for whom it was approved.

(3) To meet the medical necessity criterion, durable medical equipment must be necessary for the treatment of an illness or injury or to improve the functioning of a body part.

(4) Replacement of equipment is limited to one item every three years for adults, unless there are changes in medical necessity or are otherwise indicated in policy.

B. Medicaid covers medical supplies [~~which~~] that are necessary for an ongoing course of treatment within the limits specified in this section. As distinguished from DME, medical supplies are disposable and non-reusable items. Medicaid also covers oxygen, nutritional products and shipping charges as specified in this section. Medicaid coverage for DME and medical supplies may be limited for recipients in institutional settings when the institutions are expected to provide the necessary items. Institutional settings are hospitals, nursing facilities, intermediate care facilities for the mentally retarded and rehabilitation facilities.

C. **Covered services for non-institutionalized recipients:** Medicaid covers certain medical supplies, nutritional products and durable medical equipment provided to eligible non-institutionalized recipients without prior [~~approval~~] authorization. Medicaid covers the following for non-institutionalized

recipients:

(1) needles, syringes and intravenous (IV) equipment including pumps for administration of drugs, hyper alimentation or enteral feedings;

(2) diabetic supplies, chemical reagents, including blood, urine and stool testing reagents;

(3) gauze, bandages, dressings, pads, [~~underpads~~] and tape;

(4) catheters, colostomy, ileostomy and urostomy supplies and urinary drainage supplies;

(5) parenteral nutritional products prescribed for recipients who have a documented medical need for increased nutrition; and

(6) apnea monitors: prior authorization is required if the monitor is needed for six (6) months or longer;

(7) disposable sterile gloves are limited to 200 per month; disposable non-sterile gloves are limited to 200 per month.

D. **Covered services for institutionalized and non-institutionalized recipients:** Medicaid covers the following items without prior [~~approval~~] authorization for both institutionalized and non-institutionalized recipients:

(1) trusses and anatomical supports [~~which~~] that do not need to be made to measure;

(2) family planning devices; [~~and~~]

(3) repairs to DME; medicaid covers repair and replacement parts if recipients own the equipment for which the repair is necessary and the equipment being repaired is a covered medicaid benefit; some replacement items used in repairs may require prior authorization; repairs to augmentative and alternative communication devices require prior authorization; see Subsection C of 8.324.5.14 NMAC;

(4) replacement batteries and battery packs for augmentative and alternative communication devices owned by the recipient.

E. **Covered oxygen and oxygen administration equipment:**

(1) Medicaid covers the following oxygen and oxygen administration systems, within the specified limitations:

(a) oxygen contents, including oxygen gas and liquid oxygen;

(b) oxygen administration equipment purchase, with prior [~~approval~~] authorization: oxygen administration equipment may be supplied on a rental basis for one (1) month without prior [~~approval~~] authorization; rental beyond the initial month requires prior [~~approval~~] authorization.

(c) oxygen concentrators, liquid oxygen systems and compressed gaseous oxygen tank systems; medicaid approves the most economical oxygen delivery system possible for a specific recipient when considering types of oxygen concentrators;

(d) cylinder carts, humidifiers, regulators and flow meters;

(e) purchase of cannulae or masks; and

(f) oxygen tents and croup or pediatric tents.

(2) For recipients in nursing facilities, medicaid covers oxygen contents but does not cover oxygen administration equipment or disposable supplies associated with oxygen. The oxygen administration equipment and associated supplies must be provided by nursing facilities. If it is cost-effective to cover an oxygen concentrator rental rather than oxygen contents for gaseous systems, medicaid approves oxygen concentrator rental for recipients in nursing facilities.

(3) Rental of oxygen concentrators is limited to twelve (12) months. If the medical need for a concentrator extends beyond twelve (12) months, medicaid covers monthly service and repair fees rather than the monthly rental fee. Prior [~~approval~~] authorization must be obtained for rentals [~~which~~] that extend beyond twelve (12) months. The monthly service and repair fee includes any repairs, parts or replacement of the entire unit, as needed.

(4) Medicaid does not cover oxygen tank rental (demurrage) charges as separate charges when renting gaseous tank oxygen systems. If medicaid pays rental charges for systems, tank rental is included in the rental payments.

F. **Augmentative and alternative communication devices:** Medicaid covers medically necessary electronic or manual augmentative communication devices for medicaid recipients. Medical necessity is determined by the medical assistance division or its designee(s). Communication devices whose purpose is also educational and/or vocational are covered only when it has been determined the device meets medical criteria.

(1) A recipient must have the cognitive ability to use the augmentative communication device and meet one of the following criteria.

(a) the recipient cannot functionally communicate verbally or through gestures due to various medical conditions in which speech is not expected to be restored; or

(b) the recipient cannot verbally or through gestures participate in his/her own health care decisions (i.e., making decisions regarding medical care or indicating medical needs or communicate informed consent on medical decisions).

(2) All of the following criteria must be met before an augmentative communication device can be considered for [~~approval~~] authorization. The communication device must be:

(a) a reasonable and necessary part of the recipient's treatment plan;

(b) consistent with the symptoms, diagnosis or medical condition of the illness or injury under treatment;

(c) not furnished for the convenience of the recipient, the family, the attending practitioner or other practitioner or supplier;

(d) necessary and consistent with generally accepted professional medical standards of care (i.e., not experimental or investigational);

(e) established as safe and effective for the recipient's treatment protocol; and

(f) furnished at the most appropriate level suitable for use in the recipient's home environment.

G. **Rental of durable medical equipment:** Medicaid covers the rental of durable medical equipment. All rental payments must be applied toward purchase of the equipment. When the rental charges equal the amount allowed by medicaid for purchase, the equipment becomes the property of the recipient for whom it was approved.

(1) Medicaid does not cover routine maintenance and repairs for rental equipment.

(2) Low cost items, defined as those items for which the medicaid allowed payment is less than one hundred and fifty ($150) dollars, may only be purchased. Purchased DME becomes the property of the medicaid recipient for whom it was approved.

(3) Oxygen concentrators, ventilators and stationary liquid oxygen systems are not subject to the mandatory provisions of applying the rental payments toward purchase. See Subsection E of 8.324.5.12 NMAC, c*overed oxygen and oxygen administration equipment*.

H. **Delivery of equipment and shipping charges:** Medicaid covers the delivery of DME only when the equipment is initially purchased or rented and the round trip delivery is over seventy-five (75) miles. Providers may bill delivery charges as separate additional charges only when the providers customarily charge a separate amount for delivery to non-medicaid patients. Medicaid does not pay delivery charges for equipment purchased by medicare, for which medicaid is responsible only for the coinsurance and deductible. Medicaid covers shipping charges for DME and medical supplies when it is cost effective or practical to ship items rather than have recipients travel to pick up items. Shipping charges are defined as the actual

[~~costs~~] cost of shipping items from providers to recipients by a means other than that of provider delivery. Medicaid does not pay shipping charges for items purchased by medicare for which medicaid is only responsible for the coinsurance and deductible.

I. **Rental and purchase of used equipment:** Medicaid covers the rental and purchase of used equipment. The equipment must be identified and billed as used equipment. The equipment must have a statement of condition or warranty, and a stated policy covering liability.

J. [~~**Customized equipment**~~] **Wheelchairs and seating systems for institutionalized recipients:**

(1) Medicaid covers customized [~~durable medical equipment~~] wheelchairs and seating systems made for specific recipients, including recipients who are institutionalized. Written prior [~~approval~~] authorization is required. MAD or its designee cannot give verbal [~~approvals for customized equipment. When equipment is highly specialized and unique, items may be covered even if recipients are institutionalized.~~] authorizations for customized wheelchairs and seating systems. A customized wheelchair and seating system is defined as one that has been uniquely constructed or substantially modified for a specific recipient and is so different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes. There must be a customization of the frame for the wheelchair base or seating system to be considered customized.

(2) Repairs to a wheelchair owned by a recipient residing in an institution may be covered.

(3) Customized or motorized wheelchairs required by an institutional recipient to pursue educational or employment activity outside the institution may be covered, and will be reviewed on a case-by-case basis.

[2/1/95; 3/1/99; 8.324.5.12 NMAC - Rn, 8 NMAC 4.MAD.754.3 & A, 7/1/04]

8.324.5.13 PRIOR [~~APPROVAL~~] AUTHORIZATION AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews may be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior [~~approval~~] authorization and claims processing.

A. **Services for non-institutionalized recipients [~~which~~] that require prior [~~approval~~] authorization:** Medicaid covers certain medical supplies, nutritional products and durable medical equipment provided to eligible recipients with prior [~~approval~~] authorization. Written requests for items not included in the categories listed above or for a quantity greater than that covered by medicaid may be submitted by the recipient's physician, with a prior authorization request, to MAD for consideration of medical necessity. Please refer to criteria in 8.301.3 NMAC, *General Noncovered Services* [MAD-602.6] for durable medical equipment or medical supplies that are not covered. Medicaid covers the following benefits with prior [~~approval~~] authorization for non-institutionalized recipients:

(1) enteral nutritional supplements and products provided to recipients who must be tube fed [~~or who otherwise demonstrate a medical need for the product;~~] oral nutritional supplements when administered enterally are included;

(2) [~~adult disposable diapers prescribed for recipients who are incontinent; Recipients are limited to two (2) cases of disposable adult diapers per month.~~] nutritional supplements taken orally are not covered except for special medical foods prescribed for the treatment of inborn errors of metabolism;

(3) disposable diapers prescribed for recipients [~~under twenty-one (21) years of age~~] age three and older who suffer from neurological or neuromuscular disorders or who have other diseases associated with incontinence; diapers will be limited to up to 200 diapers per month;

(4) supports and positioning devices [~~which~~] that are part of a DME system, such as seating inserts or lateral supports for specialized wheelchairs;

(5) protective devices, such as helmets and pads;

(6) bathtub rails and other rails for use in the bathroom;

(7) electronic monitoring devices, such as electronic sphygmomanometers, oxygen saturation, fetal or blood glucose monitors and pacemaker monitors;

(8) passive motion exercise equipment;

(9) decubitus care equipment;

(10) equipment to apply heat or cold;

(11) hospital beds and full length side rails;

(12) compressor air power sources for equipment [~~which~~] that is not self-contained or cylinder driven;

(13) home suction pumps and lymph edema pumps;

(14) hydraulic patient lifts;

(15) ultraviolet cabinets;

(16) traction equipment;

(17) prone standers and walkers;

(18) trapeze bars or other patient helpers [~~which~~] that are attached to bed or freestanding;

(19) home hemodialysis and/or peritoneal dialysis systems, replacement supplies and/or accessories;

(20) wheelchairs and functional attachments to wheelchairs: wheelchairs are [~~approved~~] authorized every five (5) years; for recipients under twenty-one (21) years of age, wheelchairs can be [~~approval~~] authorized every (3) years; earlier [~~approval~~] authorization is possible when dictated by medical necessity.

(21) wheelchair trays;

(22) whirlpool baths designed for home use; [~~and~~]

(23) intermittent or continuous positive pressure breathing equipment; and

(24) manual or electronic augmentative and alternative communication devices;

(25) augmentative and alternative communication devices are [~~approved~~] authorized every five (5) years for adults and every three (3) years for recipients under twenty-one (21) years of age, unless earlier [~~approval~~] authorization is dictated by medical necessity.

B. **Services for institutionalized and non-institutionalized recipients [~~which~~] that require prior [~~approval~~] authorization:** Medicaid covers the following items with prior [~~approval~~] authorization for both institutionalized and non-institutionalized recipients:

(1) trusses and anatomical supports [~~which~~] that require fitting or adjusting by trained individuals, including JOBST hose;

(2) [~~elastic support stockings and TED type hose~~] custom-fitted compression stockings;

(3) artificial larynx prosthesis;

(4) repairs to, and replacement parts for, augmentative and alternative communication devices owned by the recipient.

C. **Additional review:** Services for which prior [~~approval~~] authorization was obtained remain subject to review at any point in the payment process.

D. **Eligibility determination:** Prior [~~approval~~] authorization does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

E. **Reconsideration:** Providers who disagree with prior [~~approval~~] authorization request denials or other review decisions can request a re-review and a reconsideration. See 8.350.2

NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953].

F. **Reasons for prior [~~approval~~] authorization denial:** Requests for prior [~~approval~~] authorization are denied for any of the following reasons:

(1) prescribing providers have not examined recipients within two (2) months or have insufficient knowledge of the recipient's condition to enable them to prescribe or recertify the need for DME;

(2) prescriptions do not document recent physician involvement in the estimate of duration of need or the recipient's condition; or

(3) requests are not signed by attending physicians: signature stamps or signatures by employees are not acceptable. [2/1/95; 3/1/99; 6/15/99; 8.324.5.13 NMAC - Rn, 8 NMAC 4.MAD.754.4 & A, 7/1/04]

8.324.5.14 SERVICE LIMITATIONS AND COVERAGE RESTRICTIONS:

A. **Non-covered multiple services:** Medicaid does not cover multiple services. Recipients are limited to one wheelchair, one hospital bed, one oxygen delivery system or one of any particular type of equipment. A back-up ventilator is covered.

B. **Special requirements for purchase of wheelchairs:** [~~Before billing for custom fabricated wheelchairs, providers who deliver chairs to recipients must make final evaluations of chairs to ensure that they meet the medical, social and environmental needs of the recipients for whom they were approved~~.] Before billing for a customized wheelchair, providers who deliver the wheelchair and seating system to a recipient must make a final evaluation to ensure that the wheelchair and seating system meets the medical, social and environmental needs of the recipient for whom it was authorized.

(1) [~~Suppliers~~] Providers assume responsibility for correcting defects or deficiencies in [~~chairs which~~] wheelchair and seating systems, that make them unsatisfactory for use by recipients.

(2) Providers are responsible for consulting physical therapists, occupational therapists, special education instructors, teachers, parents or guardians, as necessary, to ensure that the [~~recipient's needs are met by the chair~~] wheelchair meets the recipient's needs.

(3) Evaluations by a physical therapist and/or occupational therapist are required when ordering customized wheelchairs and seating systems. These therapists should be familiar with the brands and categories of wheelchairs and appropriate seating systems and work with the recipient and those consultants listed in Paragraph (2) of Subsection B of 8.324.5.14 NMAC to assure that the selected system matches physical seating needs. The physical and/or occupational therapist may not be a wheelchair vendor or under the employment of a wheelchair vendor or wheelchair manufacturer.

(4) Medicaid does not pay for special modifications or replacement of [~~custom fabricated~~] customized wheelchairs after the [~~chairs~~] wheelchairs are furnished to recipients.

(5) When the equipment is delivered to the recipient and the recipient accepts the order, the provider will submit the claim for reimbursement.

C. **Special requirements for purchase of augmentative and alternative communication devices:**

(1) [~~Requests for prior approval of augmentative communication devices must be submitted to HSD or its designee using the required form. Devices must be prescribed by the recipient's physician and be accompanied by a systematic and comprehensive speech/language evaluation completed by a speech language pathologist who is medicare certified and/or licensed by the New Mexico speech language pathology and audiology advisory board.~~] The purchase of augmentative communication devices requires prior authorization. In addition to being prescribed by a physician, the communication device must also be recommended by a speech-language pathologist, who has completed a systematic and comprehensive evaluation. The speech pathologist may not be a vendor of augmentative communication systems nor have a financial relationship with a vendor.

(2) A trial rental period of up to 60 days is required for all electronic devices to ensure that the chosen device is the most appropriate device to meet the recipient's medical needs. At the end of the trial rental period, if purchase of the device is recommended, documentation of the recipient's ability to use the communication device must be provided showing that the recipient's ability to use the device is improving and that the recipient is motivated to continue to use this device.

(3) Medicaid does not pay for supplies for augmentative and alternative communication devices, such as, but not limited to, paper, printer ribbons and computer discs.

(4) Prior [~~approval~~] authorization is required for equipment repairs.
[2/1/95; 3/1/99; 8.324.5.14 NMAC - Rn, 8 NMAC 4.MAD.754.5 & A, 7/1/04]

8.324.5.15 NONCOVERED SERVICES: Medicaid does not cover certain durable medical equipment and medical supplies. See 8.301.3 NMAC, *General Noncovered Services* [MAD-602], for an overview of the criteria used to assess whether equipment and supplies are not covered.

[~~A. Medicaid does not cover the following specific items and/or classifications of items:~~

~~(1) emesis basins;~~
~~(2) wash basins;~~
~~(3) scales;~~
~~(4) water pilks;~~
~~(5) adult adjustable leg chair;~~
~~(6) training tables;~~
~~(7) exercise balls;~~
~~(8) bath tubs;~~
~~(9) exercise mats;~~
~~(10) relaxer chairs~~
~~(11) reachers;~~
~~(12) serrated knives;~~
~~(13) wheelchair reducers;~~
~~(14) scooters;~~
~~(15) air fluidized silicone bead beds;~~
~~(16) eating utensils;~~
~~(17) neuro pak stimulators (TNS);~~
~~(18) dressing jars;~~
~~(19) pitchers;~~
~~(20) basal thermometers;~~
~~(21) postural drainage boards;~~
~~(22) electric tooth brushes;~~
~~(23) exercise weights;~~
~~(24) waterbeds;~~
~~(25) overbed tables;~~
~~(26) vibrators;~~
~~(27) lap boards;~~
~~(28) built up toothbrushes;~~
~~(29) wheelchair gloves;~~
~~(30) stair rails;~~
~~(31) straw holders;~~
~~(32) positioning devices which are not part of an approved DME system, such as back rests, wedges (module seating system), rolls, corner chair or sidelyers;~~
~~(33) supplies for augmentative and alternative communication devices, such as, paper, ribbons, computer dises, etc.~~]
[2/1/95; 3/1/99; 8.324.5.15 NMAC - Rn, 8 NMAC 4.MAD.754.6 & A, 7/1/04]

8.324.5.16 REIMBURSEMENT: Durable medical equipment or medical supply providers must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing.

A. Reimbursement for purchase or rental of DME and for nutritional products is made at the lesser of the provider's billed charges, the medicare fee schedule, or the MAD maximum allowed amount.

(1) The provider's billed charge must be the lesser of the usual and customary charge for the item or service, or the actual acquisition cost plus a percentage as described below:

(a) for items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is less than one thousand dollars ($1,000), the provider must bill the actual acquisition cost plus twenty-five percent (25%).

(b) for items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is one thousand dollars ($1,000) or greater, the provider must bill the actual acquisition cost plus fifteen percent (15%).

(2) "Usual and customary charge" refers to the amount [~~which~~] that the individual provider charges the general public in the majority of cases for a specific item or service.

(3) Medicare fees are implemented when MAD is advised by medicare of changes in the fee schedule. MAD implements medicare fees retroactively.

(4) If there is not a medicare fee schedule for the item, the MAD maximum allowed amount is the provider's actual acquisition cost plus the applicable percentage as described in Paragraph (1) of Subsection A of 8.324.5.16 NMAC.

(5) All rental payments must be applied towards purchase, with the exception of ventilators, oxygen concentrators and liquid oxygen units. Providers must keep a running total of rental charges identifying the total of all rental charges for each piece of equipment.

(6) "Set-up fees" are considered to be included in the payment for the equipment or supplies and are not reimbursed as separate charges.

B. **Reimbursement for medical supplies and home infusion drugs:** Reimbursement to providers is made at the lesser of the following:

(1) The provider's billed charge;

(a) the provider's billed charge is their usual and customary charge for services.

(b) "usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific service or item, or

(2) The maximum established by MAD, which is the department's estimated acquisition cost of the item plus twenty-five percent (25%). The department's estimated acquisition cost will be calculated using the average wholesale price less 10.5 percent (10.5%).

(3) Home infusion drugs are reimbursed at the lesser of the provider's billed charge or the MAD fee schedule.

(a) Home infusion providers will be reimbursed a dispensing fee for each package or intravenous admisture prepared and dispensed to the recipient.

(b) Reimbursement will be made at the lesser of the provider's usual and customary charge or the MAD fee schedule.

C. **Reimbursement for delivery and shipping charges:** Delivery charges are reimbursed at the MAD maximum amount per mile. Shipping charges are reimbursed at actual cost if the method used is the least expensive method of shipping. Medicaid does not pay for charges for shipping items from suppliers to the providers.

[2/1/95; 12/30/95; 3/1/01; 8.324.5.16 NMAC - Rn, 8 NMAC 4.MAD.754.7 & A, 7/1/04]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.324.6 NMAC, Sections 10 through 16, which will be effective on July 1, 2004. The Medical Assistance Division amended the sections to change the reimbursement rate for hearing aids; binaural hearing aid coverage has been addressed; section regarding institutionalized recipients was deleted; name of the state provider board was updated; and clarification to other areas were made.

This rule was also renumbered and reformatted from 8 NMAC 4.MAD.755 to comply with NMAC requirements.

8.324.6.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation applications by medical assistance division MAD, the following providers are eligible to be reimbursed for services furnished to recipients:

(1) individuals licensed to practice medicine or osteopathy;

(2) licensed audiologists certified by the American speech and hearing association; and

(3) hearing aid dealers registered and licensed by the New Mexico [~~state board of hearing aid fitters and dealers~~] speech language pathology, audiology, and hearing aid dispensing practices board.

B. Once enrolled, providers sign a provider contract and receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[2/1/95; 8.324.6.10 NMAC - Rn, 8 NMAC 4.MAD.755.1 & A, 7/1/04]

8.324.6.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records [~~which~~] that are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC, *General Provider Policies*.

[2/1/95; 8.324.6.11 NMAC - Rn, 8 NMAC 4.MAD.755.2, A, 7/1/04]

8.324.6.12 COVERED SERVICES AND SERVICE LIMITATIONS:

A. All audiology screening, diagnostic, preventive or corrective services require [~~physician referral~~] medical clearance.

B. Audiologic and/or vestibular function studies are rendered by an audiologist or a physician.

C. Within specified limitations, medicaid covers the following services when furnished by physicians, licensed audiologists or by licensed hearing aid dealers:

(1) hearing aid purchase, rental, loans, repairs, hearing aid repair and handling, and replacements:

(a) binaural hearing aid fitting will be covered for a recipient with bilateral hearing loss who is attending an educational institution, seeking employment, is employed, or for individuals with a current history of binaural fitting; or

(b) binaural hearing aid fitting will be considered, on a case-by-case basis, for a legally blind individual.

(2) hearing aid accessories and supplies, including the batteries required after the initial supply furnished at the time the hearing aid is dispensed; and

(3) hearing aid insurance against loss and breakage up to four (4) years for all purchased hearing aids; hearing aid insurance is required when the aid is dispensed; four years of hearing aid insurance is required for recipients under twenty-one (21) years of age, nursing home residents, and recipients who are mentally retarded [~~, hearing aid insurance is required when the aid is dispensed~~].

(4) replacement of hearing aids is limited to the provisions of the hearing aid insurance; the providers are responsible for obtaining insurance for every hearing aid purchased.

[2/1/95; 8.324.6.12 NMAC - Rn, 8 NMAC 4.MAD.755.3 & A, 7/1/04]

8.324.6.13 NONCOVERED SERVICES: Hearing aid and related evaluation services are subject to the limitations and coverage restrictions [~~which~~] that exist for other medicaid services. The provider must notify recipients of the coverage limitations prior to providing services. See 8.301.3 NMAC [MAD-602], *General Noncovered Services*. Medicaid does not pay for "hearing aid checks" (assessing a hearing aid for functionality). Hearing aid selection and fitting is considered included in the hearing aid dispensing fee, and will not be reimbursed separately.
[2/1/95; 8.324.6.13 NMAC - Rn, 8 NMAC 4.MAD.755.4 & A, 7/1/04]

8.324.6.14 PRIOR [~~APPROVAL~~] AUTHORIZATION AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. **Prior [~~approval~~] authorization:** The following services and procedures require prior [~~approval~~] authorization from MAD or its designee:

(1) hearing aid dispensing, purchase, rental and replacement; and

(2) hearing aid repairs for which the provider's billed charge exceeds one hundred dollars ($100.00); services for which prior [~~approval~~] authorization was obtained remain subject to review at any point in the payment process.

B. **Medical clearance:** Physician medical approval is required on any request for prior [~~approval~~] authorization for hearing aids. Physicians must certify that recipients are suitable candidates for hearing aids by signing the hearing aid evaluation/information for medicaid prior [~~approval~~] authorization form, [~~letter or other appropriate document~~] documentation on physician letterhead, or prescription document. This documentation must be submitted with the prior approval request.

[~~(1)~~] For all fittings of hearing aids on recipients under sixteen (16) years of age, recipients must be examined by physicians who are board certified in the diagnosis and treatment of diseases and conditions of the ear.

[~~(2) In the case of institutionalized recipients, physicians must certify that, in their best medical judgement, the institutionalized recipients will derive some significant benefit in terms of quality of life from the purchase of hearing aids.~~]

C. **Eligibility determination:** Prior [~~approval~~] authorization of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

D. **Reconsideration:** Providers who disagree with prior [~~approval~~] authorization request denials or other review decisions can request a re-review and a reconsideration. See 8.350.2 NMAC [MAD-953], *Reconsideration of Utilization Review Decisions*.
[2/1/95; 8.324.6.14 NMAC - Rn, 8 NMAC 4.MAD.755.5 & A, 7/1/04]

8.324.6.15 REIMBURSEMENT:

A. Hearing aid or related service providers must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing. Reimbursement to providers is made at the lesser of the following:

(1) the provider's billed charge; or

(2) the MAD fee schedule for the specific service or product.

B. The provider's billed charge must be [~~their~~] its usual and customary charge for the service or product.

C. "Usual and customary charge" refers to the amount [~~which~~] that the individual provider charges the general public in the majority of cases for a specific service or product.

D. Reimbursement for hearing aids is made at the lesser of the provider's billed charge [~~or~~], at the cost to the billing provider as indicated by the manufacturer's, distributor's or wholesaler's invoice, not to exceed MAD's maximum reimbursement limitation amounts.

E. Reimbursement for rental of hearing aids includes the following:

(1) rental charge for hearing aid; and

(2) hearing aid mold and batteries.

F. Rental payments apply to the allowed amount for purchase. When the rental payments equal the amount allowed for purchase, the aid is considered purchased.

G. Reimbursement for repairs to hearing aids is based on the MAD fee schedule. Reimbursement for repairs to hearing aids done by manufacturers is the lesser of the provider's billed charge or the manufacturer's charge for the repairs, plus a predetermined handling fee. If complications in securing the manufacturer's repair cause the provider to incur handling costs exceeding the predetermined amount established by MAD, the billing provider can be reimbursed for actual handling costs incurred if these actual costs are adequately documented.

H. Reimbursement is made for additional accessories and supplies, including batteries, when required. Reimbursement is made for an additional mold when a single aid type is used for both ears.

I. Reimbursement is made for replacement ear molds.

J. Reimbursement for insurance for hearing aid loss and accidental damage is paid at the lesser of the provider's billed charge or the maximum fee [~~established~~] allowed by MAD. If the insurance policy cost exceeds the maximum fee established by MAD, reimbursement can be made at the actual policy rate if the actual cost is documented.
[2/1/95; 8.324.6.15 NMAC - Rn, 8 NMAC 4.MAD.755.6 & A, 7/1/04]

8.324.6.16 REIMBURSEMENT LIMITATIONS:

A. **Hearing aid purchase:** Hearing aid purchase is limited to one monaural or binaural purchase per four (4) year period with the following exceptions:

(1) children under twenty-one (21) years of age, subject to prior approval;

(2) progressive hearing loss, such as otosclerosis;

(3) changes due to surgical procedures; [~~and~~]

(4) traumatic injury; and

(5) replacement of lost hearing aids, in accordance with insurance coverage.

B. **Dispensing fees:** The hearing aid dispensing fee includes payment for the services listed below. If a binaural dispensing fee is paid, it includes payment for all services listed below for both hearing aids:

(1) **Hearing aid evaluation:** Medicaid covers the evaluation for the hearing aid, subject to the following limitations:

(a) the evaluation for hearing aids is not payable to the same billing provider who bills for the hearing aid dispensing fee incidental to the purchase of a hearing aid; and

(b) the evaluation for hearing aids is not payable to a billing provider under the same corporate ownership as another billing provider who bills for the hearing aid dispensing fee incidental to the purchase of the hearing aid; therefore,

(c) physicians and/or audiologists can be reimbursed for audiologic and/or vestibular function studies in addition to a dispensing fee.

(2) hearing aid selection and fitting of the [~~aid~~] aids;

(3) testing of the hearing [~~aid~~] aids;

(4) one ear mold per hearing aid;

(5) one package of batteries per hearing aid;

(6) any other accessories required to fit the aid;

(7) all follow-up visits and adjustments necessary for a successful fitting;

(8) cleaning and adjustments for the life of the aid; and

[~~(9) assessment for hearing aid. Medicaid covers the assessment for the hearing aid, subject to the following limitations:~~

~~(a) The assessment for hearing aids is not payable to the same billing provider who bills for the hearing aid dispensing fee incident to the purchase of a hearing aid; and~~

~~(b) The assessment for hearing aids is not payable to a billing provider under the same corporate ownership as another billing provider who bills for the hearing aid dispensing fee incident to the purchase of a hearing aid.~~]

(9) shipping and handling.

C. **Audiological testing:** Hearing aid dealers and dispensers are not reimbursed for audiological, audiometric, or other hearing tests. Only licensed audiologists and physicians are reimbursed for providing these testing services.

[2/1/95; 8.324.6.16 NMAC - Rn, 8 NMAC 4.MAD.755.7 & A, 7/1/04]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.324.7 NMAC, Sections 9 through 13 and 15 through 17, which will be effective on July 1, 2004. The Medical Assistance Division amended the sections to show that transportation to pharmacies will be excluded from non-emergency transportation; reference is made to the pharmacy section for alternatives to transportation; added clarification regarding documentation requirements for medical attendants; and clarification was made in other sections. This rule was also renumbered and reformatted from 8 NMAC 4. MAD.756.

8.324.7.9 TRANSPORTATION SERVICES: Transportation services are reimbursed by the New Mexico medical assistance program (medicaid) under Title XIX of the Social Security Act, as amended. Medicaid covers expenses for transportation and other related expenses [~~which~~] that the New Mexico medical assistance division (MAD) determines are necessary to secure medicaid-covered medical examinations and treatment for eligible recipients in or out of their home community [42 CFR Section 440.170]. Travel expenses include the cost of transportation by public transportation, taxicab, handivan, and ground or air ambulance. Related travel expenses include the cost of meals and lodging made necessary by receipt of medical care away from the recipient's home community. When medically necessary, medicaid covers similar expenses for an attendant who accompanies the recipient to the medical examination or treatment. This part describes the types of providers eligible to furnish transportation and related expenses, covered services, service limitations and reimbursement methodology.

[2/28/98; 8.324.7.9 NMAC - Rn, 8 NMAC 4.MAD.756 & A, 7/1/04]

8.324.7.10 ELIGIBLE PROVIDERS: Upon approval of New Mexico medical assistance program provider participation applications by MAD, the following providers are eligible to be reimbursed for providing transportation or transportation related services to recipients:

A. air ambulances certified by the state of New Mexico department of health, emergency medical services bureau;

B. ground ambulance services certified by the New Mexico [~~state corporation~~] public regulation commission or by the appropriate state licensing body for out-of-state ground ambulance services, within those geographic regions in the state specifically authorized by the New Mexico [~~state corporation~~] public regulation commission;

C. non-emergency transportation vendors (taxicab, vans and other vehicles) and certain bus services certified by the New Mexico [~~state corporation~~] public regulation commission, within those geographic regions in the state specifically authorized by the New Mexico [~~state corporation~~] public regulation commission;

D. common carriers, [~~which~~] that include buses, trains and airplanes;

E. certain carriers exempted or warranted by the New Mexico [~~corporation~~] public regulation commission within those geographic regions in the state specifically authorized by the New Mexico [~~state corporation~~] public regulation commission; and

F. lodging and meal providers.

[2/28/98;8.324.7.10 NMAC - Rn, 8 NMAC 4.MAD.756.1 & A, 7/1/04]

8.324.7.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records [~~which~~] that are sufficient to fully disclose the extent and nature of the services provided to recipients. See 8.302.1 NMAC, *General Provider Policies*.

[2/28/98; 8.324.7.11 NMAC - Rn, 8 NMAC 4.MAD.756.2 & A, 7/1/04]

8.324.7.12 COVERED SERVICES AND SERVICE LIMITATIONS: Medicaid reimburses recipients or transportation providers for transportation only if a recipient does not have access to transportation services [~~which~~] that are available free of charge.

A. **Free alternatives examples:** Alternative transportation services [~~which~~] that can be provided free of charge include volunteers, relatives or transportation services provided by nursing facilities or other residential centers. Recipients must certify in writing that they do not have access to free alternatives.

B. **Least costly alternatives:** Medicaid covers the most appropriate and least costly transportation alternatives suitable for the recipient's medical condition. If recipients can use private vehicles or less costly public transportation, those alternatives must be used before recipients can use more expensive transportation alternatives.

C. **Non-emergency transportation service:** Medicaid covers non-emergency transportation services for [~~clients~~] recipients who have no primary transportation and who are unable to access a less costly form of public transportation.

D. **Long distance common carriers:** Medicaid covers long distance services furnished by a common carrier if recipients must leave their home communities to receive medical services. Authorization forms for direct payment to long distance bus common carriers by MAD are available through local county ISD offices.

E. **Ground ambulance services:** Medicaid covers services provided by ground ambulances when:

(1) An emergency [~~which~~] that requires ambulance service is certified by a physician or is documented in the provider's records as meeting emergency

medical necessity criteria. Terms are defined as follows:

(a) "Emergency" is defined as a [~~situation caused by an unforeseen accident, injury or acute illness demanding immediate action and transport to a place for treatment;~~] medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part.

(b) "Medical necessity" for ambulance services is established if the recipient's physical, mental or behavioral health condition is such that the use of any other method of transportation is contraindicated and would endanger the recipient's health.

(2) Scheduled, non-emergency ambulance services are ordered by a physician who certifies that the use of any other method of non-emergency transportation is contraindicated by the recipient's [~~medical~~] physical, mental or behavioral health condition. Medicaid covers non-reusable items and oxygen required during transportation. Coverage for these items [~~are~~] is included in the base rate reimbursement for ground ambulance.

F. **Air ambulance services:** Medicaid covers services provided by air ambulances, which include private airplanes, if an emergency exists and the medical necessity for the service is certified by the physician.

(1) [~~"Emergency"~~] An emergency that would require air over ground ambulance services is defined as a medical condition, including emergency labor and delivery, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in one of the following:

(a) individual's death;

(b) placement of individual's health in serious jeopardy;

(c) serious impairment of bodily functions; or

(d) serious dysfunction of any bodily organ or part.

(2) [~~medicaid covers the following services for air ambulances~~] Coverage for these items is included in the base rate reimbursement for air ambulance:

(a) non-reusable items and oxygen required during transportation;

(b) professional attendants required during transportation;

(c) detention time or standby time [~~up to one (1) hour without physician documentation. If the detention or standby time is more than one (1) hour, a statement from the attending physician or flight nurse justifying the additional time is required~~]; and

(d) use of equipment required during transportation [~~, if included in the MAD fee schedule~~].

G. **Lodging services:** Medicaid covers lodging services if recipients are required to travel to receive medical services more than four (4) hours one way and an overnight stay is required due to medical necessity or cost considerations. If medically justified and approved, lodging is initially set for up to five (5) continuous days. For a longer stay, the need for lodging must be re-evaluated by the fifth day to authorize up to an additional fifteen (15) days. Re-evaluation must be made every fifteen (15) days for extended stays, prior to the expiration of the existing authorization. Approval of lodging is based on the medical provider's statement of need. Authorization forms for direct payment by MAD to medicaid lodging providers [~~by MAD~~] are available through local county income support division (ISD) offices.

H. **Meal services:** Medicaid covers meals if a recipient is required to leave [~~their~~] his home community for eight (8) hours or more to receive medical services. Authorization forms for direct payment to medicaid meal providers by MAD are available through local county ISD offices.

I. **Coverage for attendants:** Medicaid covers transportation, meals and lodging [~~, in the same manner as for recipients,~~] for one attendant if the medical necessity for the attendant is certified in writing justified by the recipient's medical provider or the recipient who is receiving medical service is under eighteen (18) years of age. The attendant for a child under eighteen (18) years of age should be the parent or legal guardian. If the medical appointment is for an adult recipient, medicaid does not cover transportation services or related expenses of children under eighteen (18) years of age traveling with the adult recipient.

J. **Coverage for medicaid waiver recipients:** Transportation to medicaid waiver facilities will be covered for medicaid waiver recipients receiving occupational therapy, physical therapy, speech therapy, and behavioral therapy services.

[12/30/95; 2/28/98; 8.324.7.12 NMAC - Rn, 8 NMAC 4.MAD.756.3 & A, 7/1/04]

8.324.7.13 NONCOVERED SERVICES: Transportation services are subject to the same limitations and coverage restrictions [~~which~~] that exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services* [MAD-602]. Medicaid will not pay to transport recipients to a medical service [~~which~~] that is not covered under the medicaid program. Providers must notify recipients of medicaid-covered and non-covered services prior to providing services. See 8.302.1, *General Provider Policies*. Transportation to pharmacy providers is not a covered benefit. Please see Subsection F of 8.324.4.18 NMAC, *Pharmacy Services*, for alternatives.

[12/30/95; 2/28/98; 8.324.7.13 NMAC - Rn, 8 NMAC 4.MAD.756.4 & A, 7/1/04]

8.324.7.15 PRIOR [~~APPROVAL~~] AUTHORIZATION AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive utilization review instructions and documentation forms necessary for prior [~~approval and claims processing. Non-emergency transportation for medicaid client over 65 miles are subject to retrospective review.~~] authorization and claims processing.

A. **Prior [~~approval~~] authorization:** Certain procedures or services may require prior [~~approval~~] authorization from MAD or its designee. Services for which prior [~~approval~~] authorization is received remain subject to utilization review at any time during the payment process.

B. **Referrals for travel outside the home community:**

(1) If a recipient must travel over sixty-five (65) miles from [~~their~~] his home community to receive medical care, the [~~medicaid primary care network provider,~~] designated medicaid medical management provider[~~,~~] or the medicaid primary care provider in the home community must provide the following information to the non-emergency transportation provider:

(a) the medical and/or diagnostic service the recipient is being referred for;

(b) the name of the out of community medical provider; and

(c) justification that the medical care is not available in the home community.

(2) Referrals and referral information must be obtained from a medicaid provider. For continued out of community non-emergency transportation, the required information must be obtained every six (6)

months regardless of the frequency of transport.

C. **Eligibility determination:** Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

D. **Reconsideration:** Providers [~~or recipients~~] who are dissatisfied with a utilization review decision or action can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953].

[12/30/95; 2/28/98; 8.324.7.15 NMAC - Rn, 8 NMAC 4.MAD.756.6 & A, 7/1/04]

8.324.7.16 REIMBURSEMENT:

A. Transportation providers must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing. Reimbursement to transportation providers for covered services is made at the lesser of the following.

(1) The provider's billed charge:

(a) The billed charge must be the provider's usual and customary charge for services. For providers with tariffs, the billed charge must be the lesser of the charges allowed by the provider's tariff or the provider's usual and customary charge.

(b) "Usual and customary charge" refers to the amount an individual provider charges the general public in the majority of cases for a specific procedure or service, or

(2) The MAD fee schedule for the specific service or procedure. Reimbursement by the medicaid program to transportation providers is inclusive of gross-receipts taxes and other applicable taxes. Air ambulance providers are exempt from paying gross receipts tax[~~,~~] ; therefore, the maximum rates paid for air ambulance service will not include gross receipts tax. [~~Air ambulance providers will be reimbursed separately for federal excise tax.~~]

B. **Ground ambulances:** Providers of ground ambulance services are reimbursed at the lesser of their billed charge for the service or the MAD maximum allowed amount.

(1) The MAD maximum allowed amount for transports up to 15 miles is limited to the base rate amount. The allowable base rate for advanced life support (ALS) or basic life support (BLS) includes reimbursement for the ALS or BLS equipped service, oxygen, disposable supplies and medications used in transport. The base rate reimbursement includes mileage reimbursement for the first 15 miles of transport.

(2) The allowable base rate for a scheduled non-emergency transport includes reimbursement for oxygen, disposable supplies and medications used in transport. The base rate includes mileage reimbursement for the first 15 miles of transport.

C. **Air ambulances:** Providers of air ambulance services are reimbursed at the lesser of billed charges or the MAD maximum allowed rate.

D. **Non-emergency transportation services:**

(1) Providers of non-emergency transportation are reimbursed at the lesser of their approved tariff or the medicaid rate for one or multiple [~~client~~] recipient transports not meeting the "additional passenger" criteria [~~(No. 4~~] Paragraph 4, below).

(2) Providers of non-emergency transportation will be reimbursed at a reduced per mile rate when a provider reaches total mileage transports of five million miles (5,000,000) during any medicaid calendar year. The provider will then be reimbursed at the lesser of [~~their~~] its approved non-medicaid tariff or the medicaid reduced rate.

(3) Reimbursement will [~~not exceed $200 for any single~~] be limited to MAD's reimbursement limitation per one-way trip for a medicaid recipient being transported for medical care. Medicaid does not provide reimbursement for any portion of the trip for which the medicaid-eligible recipient is not in the vehicle.

(4) Reimbursement will be limited to MAD's reimbursement limitation per one-way trip for a medical attendant accompanying a medicaid recipient being transported for medical care.

(5) An "additional passenger transport" is a non-emergency transport of two or more medicaid clients who are picked up at the same location and are being transported to the same provider. Additional passenger transport services will not be covered. When more than one [~~client~~] recipient is being transported from the same location to the same provider and each [~~client~~] recipient has a scheduled medicaid-covered medical appointment, medicaid will allow coverage for one [~~client~~] recipient and one medical attendant, if medically indicated. Additional passengers will not be covered.

(6) Medicaid covers transportation for one attendant, not meeting the additional passenger criteria [~~No. 4~~] in Paragraph 4, above, if the medical necessity for the attendant is justified in writing by the recipient's medical provider [~~or~~] for each transport. In cases where the recipient's condition is ongoing and the need for a medical attendant will not change, the attestation must only be renewed every six months, unless the recipient who is receiving medical service is under eighteen (18) years of age. The attendant for a child under eighteen (18) years of age should be the parent or legal guardian. If the medical appointment is for an adult recipient, medicaid does not cover transportation services or related expenses of children under eighteen (18) years of age traveling with the adult recipient.

(7) Medicaid covers transportation to scheduled, structured counseling and therapy sessions for recipients, families, or multi-family groups, based on individualized needs as specified in the treatment plan. Claims for services are to be filed under the name of the medicaid recipient being primarily treated through these sessions.

[12/30/95; 8.324.7.16 NMAC - Rn, 8 NMAC 4.MAD.756.7 & A, 7/1/04]

8.324.7.17 CLIENT MEDICAL TRANSPORTATION FUND: In non-emergency situations, recipients may request reimbursement from the client medical transportation (CMT) fund through their local county ISD office for money spent on transportation and related expenses. For reimbursement from the CMT fund, appointments for which reimbursement is requested must have occurred within thirty (30) calendar days of the completed request for reimbursement.

A. **Submission of medical verification forms:** Unless medical service providers return the signed medical appointment verification form to the address on the back of the form, a recipient will not be reimbursed for the travel and related expenses. The signed form indicates that the recipient kept the appointment(s) for which the CMT fund reimbursement is requested. For medical services, such as vision services, written receipts confirming the dates of service must be given to the recipient for submission to the local county ISD office.

B. **Preparation of referrals for travel outside the home community:** If a recipient must travel over sixty-five (65) miles from [~~their~~] his home community to receive medical care, [~~the primary care network provider,~~] designated medical management provider, or primary care provider in the home community must furnish a written referral and written statement that the services are not available within the recipient's home community. Referrals and documentation must be obtained from a medicaid provider. The document is submitted to the local county ISD office to authorize mileage per diem and related expenses, as appropriate.

C. **Fund advances in**

emergency situations: Money from the CMT fund is advanced for travel only if an emergency exists. "Emergency", in this situation, is defined as a non-routine, unforeseen accident, injury or acute illness demanding immediate action and for which transportation arrangements could not be made five (5) calendar days in advance of the visit to the provider. Advance funds must be requested and disbursed prior to the medical appointment. A medical appointment verification form and/or written referral must be received by the ISD office within thirty (30) days from the date of the medical appointment for which the advance funds were requested.

[12/30/95; 8.324.7.17 NMAC - Rn, 8 NMAC 4.MAD.756.8 & A, 7/1/04]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.324.8 NMAC, Sections 11 through 16 which will be effective July 1, 2004. The Medical Assistance Division amended language to limit the coverage of compression stockings, limit the coverage of orthopedic shoes, and add eye prosthesis and prosthetic services to this Part. This rule was also renumbered and reformatted from 8 NMAC 4. MAD.757.

8.324.8.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records [~~which~~] that are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC, *General Provider Policies*

[2/1/95; 8.324.8.11 NMAC - Rn, 8 NMAC 4.MAD.757.2 & A, 7/1/04]

8.324.8.12 COVERED SERVICES AND SERVICE LIMITATIONS: Medicaid covers medically necessary prosthetics and orthotics supplied by providers only when specified requirements or conditions are satisfied. Prosthetic devices are replacements or substitutes for a body part or organ, such as an artificial limb or an eye prosthesis. Orthotic devices support or brace the body, such as trusses, [~~elastic~~] compression custom-fabricated stockings and braces. **Conditions of coverage:** Medicaid covers prosthetics and orthotics only when all the following conditions are met:

A. the device has been ordered by a physician or other licensed practitioner and is medically necessary for recipient mobility, support or physical functioning;

B. the need for the device is not satisfied by the existing device the recipient currently has; and

C. the device is covered by medicaid and any required prior approval requirements have been satisfied;

D. coverage of compression stockings for adults is limited to stockings that are custom-fabricated to meet the recipient's medical needs;

E. coverage of orthopedic shoes for adults is limited to the shoe that is attached to a leg brace;

F. replacement of items is limited to one item every three years, unless there are changes in medical necessity.

[~~B. **Items not covered by this section:** Medicaid can cover some items; however, the conditions and limitations of coverage are delineated in other section of this manual.~~

~~(1) Ostomy supplies and accessories are considered medical supplies. See Section MAD-754, Durable Medical Equipment and Medical Supplies.~~

~~(2) Wheelchairs, crutches and other equipment for mobility are considered durable medical equipment. See Section MAD-754, Durable Medical Equipment and Medical Supplies.~~

~~(3) Nutritional supplements hyperalimentations and total parenteral nutrition (TPN) are considered drug services, while the equipment to administer them is durable medical equipment. See Section MAD-754, Durable Medical Equipment and Medical Supplies and Section MAD-753, Pharmacy Services.~~

~~(4) Eye prostheses are subject to the regulations in Section MAD-715, Vision Care Services.~~

~~(5) Hearing aids and devices are subject to the regulations in Section MAD-755, Hearing Aid and Related Evaluations.~~

~~(6) Dentures are subject to the regulations contained in Section MAD-716, Dental Services.~~

~~(7) Surgically implanted prostheses are subject to the regulations in Section MAD-721, Hospital Services or other sections of this manual for providers who can purchase the prosthesis for surgical use.~~

~~(8) Augmentative and Alternative communication devices (AACs) are subject to the regulations in Section MAD-754, Durable Medical Equipment and Medical Supplies.~~]

[2/1/95; 3/1/99; 8.324.8.12 NMAC - Rn, 8 NMAC 4.MAD.757.3 & A, 7/1/04]

8.324.8.13 NONCOVERED SERVICES: Prosthetic and orthotic services are subject to the limitations and coverage restrictions [~~which~~] that exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services* [MAD-602]. [~~Medicaid does not cover the following specific prosthetics and orthotics:~~] In addition to the services identified in 8.301.3 NMAC [MAD-602], *General Noncovered Services*, the following services are not covered:

A. [~~orthopedics shoes, unless they are an integral part of a leg brace;~~]

[~~B.~~] orthotic supports for the arch or other supportive devices for the foot, unless they are integral parts of a leg brace;

[~~C.~~] B. prosthetic devices or implants [~~which~~] that are used primarily for cosmetic purposes;

[~~D. penile implant prostheses;~~]

[2/1/95; 3/1/99 8.324.8.13 NMAC - Rn, 8 NMAC 4.MAD.757.4 & A, 7/1/04]

8.324.8.14 PRIOR [~~APPROVAL~~] AUTHORIZATION AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. **Prior [~~approval~~] authorization:** All prosthetic devices require prior [~~approval~~] authorization from MAD or its designee. The only exception to the prior [~~approval~~] authorization requirement is for prosthetic limbs attached immediately following surgery for traumatic injuries while the recipient is a hospital inpatient. Prior [~~approval~~] authorization is required for orthotic devices for the foot or for shoes. Services for which prior [~~approval~~] authorization was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior [~~approval~~] authorization of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. **Reconsideration:** Providers who disagree with prior [~~approval~~] authorization request denials or other review decisions can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization*

Review Decisions, [MAD-953].
[2/1/95; 8.324.8.14 NMAC - Rn, 8 NMAC 4.MAD.757.5 & A, 7/1/04]

8.324.8.15 REIMBURSEMENT:

A. Prosthetic and orthotic service providers must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing. Reimbursement to providers is made at the lesser of the following:

(1) the provider's billed charge; or

(2) the MAD fee schedule for the specific service or item.

B. The provider's billed charge must be their usual and customary charge for services.

C. "Usual and customary charge" refers to the amount [~~which~~] that the individual provider charges the general public in the majority of cases for a specific item or service.

D. Reimbursement for repairs made by the provider is made at the actual repair cost plus fifty percent (50%). Repairs made by the manufacturer are reimbursed to the provider at the actual manufacturer's repair cost plus a handling fee of twenty dollars ($20.00). If complications in securing the [~~repair cause the provider to incur handling costs exceeding the handling fee allowed, the provider can be reimbursed for actual handling costs by documenting those costs~~] manufacturer's repair cause the provider to incur handling costs exceeding the predetermined amount established by MAD, the billing provider can be reimbursed for actual handling costs incurred if these actual costs are adequately documented.

E. Reimbursement for additional accessories and supplies is made at the lower of the actual cost of the supply or accessory or the fee established by MAD for the particular item.
[2/1/95; 8.324.8.15 NMAC - Rn, 8 NMAC 4.MAD.757.6 & A, 7/1/04]

8.324.8.16 REIMBURSEMENT LIMITATIONS:

A. **Reimbursement for adjustments, modification and fitting:** The amount billed for the item includes all minor attachments, adjustments, additions, modifications, fittings and other services necessary to make the device functional. These items cannot be billed separately.

(1) Medicaid does not cover an additional charge for a hospital visit or home visit if fittings or measurements take place away from the provider's office.

(2) If the place of service is outside the provider's city limits, mileage can be billed for travel to the place of service.

(3) A prosthetic or orthotic device for a recipient hospitalized in a diagnostic related group (DRG) reimbursed hospital is reimbursed by DRG methods described in 8.311.3 NMAC, *Methods and Standards for Establishing Payment Rates-Inpatient Hospital Services*.

B. **Date of service:** The date of service declared on a claim is the date when the device is supplied to the recipient, not the fitting date or measuring date.

C. **No specification of brand or quality:** When a physician requests an item and does not specify the brand or quality of the item to be dispensed, the item chosen must be of a quality and cost which adequately serves the purpose for which the device is required. [~~It is considered medicaid fraud to supply an item for which the quality or cost exceeds that which would be reasonable or necessary for a similarly situated non-medicaid patient.~~]
[2/1/95 8.324.8.16 NMAC - Rn, 8 NMAC 4.MAD.757.7 & A, 7/1/04]

NEW MEXICO STATE PERSONNEL BOARD

This is an amendment to Subsection B of 1.7.10.13 NMAC, effective 06/08/04. This amendment is the result of action taken by the State Personnel Board in relation to their authority under Emergency Rules, 1.7.13.11 NMAC (07/07/01). This amendment expires 120 calendar days after filing.

1.7.10.13 INVOLUNTARY OR VOLUNTARY SEPARATION:

A. Employees who have suffered a job-related injury or illness which is compensable under the Workers' Compensation Act and are physically or mentally unable to perform the essential functions of their pre-injury/pre-illness position, with or without reasonable accommodation, shall be involuntarily or voluntarily separated from the service without prejudice provided:

(1) the employee has been afforded modified duty in accordance with ***1.7.10.12 NMAC***;

(2) the employee has reached maximum medical improvement prior to the completion of up to 12 months of modified duty; or, the employee has not reached maximum medical improvement upon the expiration of up to 12 months of modified duty;

(3) all efforts to reasonably accommodate the medical restrictions of the employee have been made and documented; and

(4) the employing agency has exhausted efforts to find other suitable vacant positions within the agency at the same or lower midpoint than the midpoint of the pre-injury/pre-illness position for which:

(a) the employee meets the established requirements and can perform the essential functions of the job, either with or without reasonable accommodation, or

(b) the agency certifies that the employee holds qualifications and abilities necessary for successful job performance and can perform the essential functions of the job, either with or without reasonable accommodation.

[~~B.~~ ~~Employees who have suffered a non-job-related injury or illness and are permanently unable to perform the essential functions of their pre-injury/pre-illness position, with or without reasonable accommodation, as a result of the physical or mental disability created by the non-job-related injury or illness shall be involuntarily or voluntarily separated from the service without prejudice provided:~~

~~**(1)** all efforts to reasonably accommodate the medical restrictions of the employee have been made and documented; and~~

~~**(2)** the employing agency has exhausted efforts to find other suitable vacant positions within the agency at the same or lower midpoint than the midpoint of the pre-injury/pre-illness position for which:~~

~~**(a)** the employee meets the established requirements and can perform the essential functions of the job, either with or without reasonable accommodation; or~~

~~**(b)** the agency certifies that the employee holds qualifications and abilities necessary for successful job performance and can perform the essential functions of the job, either with or without reasonable accommodation.~~]

[~~C~~] B. Agencies may provide modified duty to employees for a period of up to 4 months during the separation process if required to meet the provisions of this rule.

[~~D~~] C. Employees involuntarily or voluntarily separated in accordance with ***1.7.10.13 NMAC*** shall be provided with at least 14 calendar days written notice. Such separation is not appealable to the board.

[~~E~~] D. The agency shall notify the director and the risk management division of the general services department of the proposed separation 30 calendar days in advance of the separation date and submit a copy of the separation notice along with documentation to support efforts to modify pre-injury/pre-illness positions and to sup-

port efforts to find other suitable vacant positions.
[1.7.10.13 NMAC - Rp, 1 NMAC 7.10.13, 07/07/01; A, 11/14/02; A, 06/08/04]
[This amendment is the result of action taken by the state personnel board in relation to their authority under Emergency Rules, 1.7.13.11 NMAC (07/07/01). This amendment expires 120 calendar days after filing.]

NEW MEXICO BOARD OF PHARMACY

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 19 PHARMACISTS
PART 29 CONTROLLED SUBSTANCE PRESCRIPTION MONITORING PROGRAM

16.19.29.1 ISSUING AGENCY: Regulation and Licensing Department - Board of Pharmacy.
[16.19.29.1 NMAC - N, 07-15-04]

16.19.29.2 SCOPE: All persons or entities that dispense controlled substances pursuant to prescriptions from practitioners.
[16.19.29.2 NMAC - N, 07-15-04]

16.19.29.3 STATUTORY AUTHORITY: Section 30-31-16 of the Controlled Substance Act. 30-31-1 through 30-31-42 NMSA 1978, authorizes the board of pharmacy to promulgate regulations and charge reasonable fees regarding controlled substances. 30-31-16 authorizes the board to collect information regarding controlled substances.
[16.19.29.3 NMAC - N, 07-15-04]

16.19.29.4 DURATION: Permanent.
[16.19.29.4 NMAC - N, 07-15-04]

16.19.29.5 EFFECTIVE DATE: 07-15-04, unless a later date is cited at the end of a section.
[16.19.29.5 NMAC - N, 07-15-04]

16.19.29.6 OBJECTIVE: The objective of Part 29 of Chapter 19 is to promote the public health and welfare by detecting and preventing substance abuse and encouraging appropriate treatment of pain and other conditions for which controlled substances are prescribed. The purpose of the system is to improve access to controlled substances for legitimate medical needs by allowing a practitioner or a pharmacist to obtain a patient's pharmaceutical history related to controlled substances. The program's objectives will include education of the public and health care professionals regarding the nature and extent of the problem of drug abuse, appropriate prescribing and use of controlled substances, and the medical treatment options for abusers of controlled substances and pain management.
[16.19.29.6 NMAC - N, 07-15-04]

16.19.29.7 DEFINITIONS:

A. "Controlled substance" has the meaning given such term in 30-31-2 NMSA.

B. "Board of pharmacy" means the state agency responsible for the functions listed in 16.19.29.8 NMAC.

C. "Patient" means the person or animal who is the ultimate user of a drug for whom a prescription is issued and for whom a drug is dispensed.

D. "Dispenser" means the person who delivers a schedule II - V controlled substance as defined in subsection E to the ultimate user, but does not include the following:

(1) a licensed hospital pharmacy that distributes such substances for the purpose of inpatient hospital care;

(2) a practitioner, or other authorized person who administers such a substance; or

(3) a wholesale distributor of a schedule II - V controlled substance.

E. "Schedule II, III, IV and V controlled substance" means substances that are listed in schedules II, III, IV, and V of the schedules provided under 30-31-5 to 30-31-10 of NMSA or the federal controlled substances regulation (21 U.S.C. 812).

F. "Report" means a compilation of data concerning a patient, a dispenser, a practitioner, or a controlled substance.
[16.19.29.7 NMAC - N, 07-15-04]

16.19.29.8 REQUIREMENTS FOR THE PRESCRIPTION MONITORING PROGRAM:

A. The board shall monitor the dispensing of all schedule II, III, and IV controlled substances by all pharmacies licensed to dispense such substances to patients in this state.

B. Each dispenser shall submit to the board by electronic means information regarding each prescription dispensed for a drug included under Subsection A of this section. Information to be reported shall conform to the standards developed by the American society for automation in pharmacy (ASAP) and published in the "ASAP telecommunications format for controlled substances", 1995 edition. Information submitted for each prescription shall include:

(1) dispenser DEA number;
(2) date prescription filled;
(3) prescription number;
(4) whether the prescription is new or a refill;
(5) NDC code for drug dispensed;
(6) quantity dispensed;
(7) patient name;
(8) patient address;
(9) patient date of birth;
(10) prescriber DEA number;
(11) date prescription issued by prescriber;
(12) and if available, the diagnosis code using the current version of the international classification of diseases.

C. Each dispenser shall submit the information in accordance with transmission methods and frequency established by the board; but shall report at least every thirty days, between the 1st and 15th of the month following the month the prescription was dispensed. A record of each controlled substance prescription dispensed must be transmitted to the boards' agent by computer modem, computer disk, cassette tape or other acceptable electronic format monthly.

D. The board may issue a waiver to a dispenser that is unable to submit prescription information by electronic means. Such waiver may permit the dispenser to submit prescription information by paper form or other means, provided that all information required in subsection B of this section is submitted in this alternative format.
[16.19.29.8 NMAC - N, 07-15-04]

16.19.29.9 ACCESS TO PRESCRIPTION INFORMATION:

A. Prescription information submitted to the board shall be confidential and not subject to public or open records laws, except as provided in Subsections C, D and E of 16.19.29.9 NMAC.

B. The board shall maintain procedures to ensure that the privacy and confidentiality of patients and patient information collected, recorded, transmitted, and maintained is not disclosed to persons except as in Subsection C, D, and E of this 16.19.29.9 NMAC.

C. After receiving a complaint, the board inspectors shall review the relevant prescription information. If there is reasonable cause to believe a violation of law or breach of professional standards may have occurred, the board shall notify the appropriate law enforcement or professional licensing, certification or regulatory agency or entity, and provide prescription information required for an investigation.

D. The board will establish written protocols for reviewing the pre-

scription data reported. These protocols will be reviewed and approved by the board as needed but at least once every calendar year. These protocols will define information to be screened, frequency and thresholds for screening and the parameters for using the data. Data will be used to notify providers, patients and pharmacies to educate, provide for patient management and treatment options.

E. The board shall be authorized to provide data in the prescription monitoring program to the following persons:

(1) persons authorized to prescribe or dispense controlled substances, for the purpose of providing medical or pharmaceutical care for their patients;

(2) an individual who request's their own prescription monitoring information in accordance with procedures established under 61-11-2.D NMSA, 1978 and Subsection G of 16.19.6.23 NMAC.

(3) New Mexico medical board, New Mexico board of nursing, New Mexico board of veterinary medicine, New Mexico board of dental health care, board of examiners in optometry, osteopathic examiners board, acupuncture & oriental medicine board, and podiatry board for their licensees;

(4) professional licensing authorities of other states if their licensees practice in the state or prescriptions provided by their licensees are dispensed in the state;

(5) local, state and federal law enforcement or prosecutorial officials engaged in an ongoing investigation of an individual in the enforcement of the laws governing licit drugs;

(6) human services department regarding medicaid program recipients;

(7) metropolitan, district, state or federal court(s) under grand jury subpoena or criminal court order;

(8) personnel of the board for purposes of administration and enforcement of this regulation, or 16.19.20 NMAC.

F. The board shall provide data to public or private entities for statistical, research, or educational purposes after removing information that could be used to identify individual patients and persons who have received prescriptions from dispensers.

[16.19.29.9 NMAC - N, 07-15-04]

16.19.29.10 REPORTS: A written request will be filed with the board prior to release of a report.

A. Persons listed in Paragraphs (1) through (5) of Subsection D of 16.19.29.9 NMAC must submit a written request listing the information for the report. Practitioners, agencies and/or boards or commissions should prepare the request on letterhead.

B. Written reports will be prepared and delivered to the requesting person via U.S. mail.

C. Reports may be provided by secured electronic means after verification of electronic request.

D. The board will develop a system that provides timely access to prescription information to the healthcare providers using current technologies.

E. The board shall receive a quarterly program outcomes report from staff or contractors. A statistical analysis of the data that does not include protected information should be reported on the web site or in the newsletter.

[16.19.29.10 NMAC - N, 07-15-04]

16.19.29.11 AUTHORITY TO CONTRACT: The board is authorized to contract with another agency of this state or with a private vendor, as necessary, to ensure the effective operation of the prescription monitoring program. Any contract shall be bound to comply with the provisions regarding confidentiality of prescription information in 16.19.29.9 NMAC of this regulation and shall be subject to the penalties specified in 16.19.29.12 NMAC of this regulation for unlawful regulations.

[16.19.29.11 NMAC - N, 07-15-04]

16.19.29.12 PENALTIES:

A. A dispenser who knowingly fails to submit prescription monitoring information to the board as required by this regulation or knowingly submits incorrect prescription information shall be subject to disciplinary proceedings as defined in 61-11-20 NMSA.

B. A person authorized to have prescription monitoring information pursuant to this regulation who knowingly discloses such information in violation of this regulation shall be subject to criminal proceedings as described in 26-1-16.D and 26-1-26 NMSA.

C. A person authorized to have prescription monitoring information pursuant to this regulation who uses such information in a manner or for a purpose in violation of this regulation shall be subject to criminal proceedings as described in 26-1-16.D and 26-1-26 NMSA.

[16.19.29.12 NMAC - N, 07-15-04]

16.19.29.13 SEVERABILITY: If any provisions of this regulation or application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the regulation which can be given effect without the invalid provisions or applications, and to this end the provisions of this regulation are severable.

[16.19.29.13 NMAC - N, 07-15-04]

HISTORY OF 16.19.29 NMAC: [RESERVED]

NEW MEXICO BOARD OF PHARMACY

This is an amendment to 16.19.12 NMAC, Sections 12 and 13, effective 07-15-2004.

16.19.12.12 LICENSE/REGISTRATION RENEWAL:

A. Pharmacist license renewal for active $200.00 **bi-ennialy**

B. Pharmacist license renewal for in-active $70.00 **bi-ennialy**

C. Intern renewal $30.00 per year

D. Duplicate license for interns and pharmacists $10.00

E. Controlled substance registration $60.00

F. Duplicate license for controlled substance $10.00

G. Pharmacy technician renewal $30.00 bi-ennialy

[~~H. Manufacturer Representative $100.00 bi-ennialy~~]

[~~I~~]**H**. Pharmacist clinician $70.00 bi-ennialy

[03-07-80...08-27-90; A, 07-31-98; A, 11-14-98; 16.19.12.12 NMAC - Rn, 16 NMAC 19.12.12, 03-30-02; A, 12-15-02; A, 09-30-03; A, 07-15-04]

16.19.12.13 LICENSE FEES:

A. License fee for drug manufacturer [~~$300.00~~] **$5000.00 for 1 year or $10,000.00 for 2 years. Upon implementation of a federal medicare prescription drug benefit program, the annual fee shall revert to $1000.00 annually.**

B. Wholesale drug distributor [~~$300.00~~] **$5000.00 for 1 year or $10,000.00 for 2 years. Upon implementation of a federal medicare prescription drug benefit program, the annual fee shall revert to $1000.00 annually.**

C. Drug manufacturer/repackager [~~$300.00~~] **$5000.oo for 1 year or $10,000.00 for 2 years. Upon implementation of a federal medicare prescription drug benefit program, the annual fee shall revert to $1000.00 annually.**

D. Repackager [~~$300.00~~] **$5000.00 for 1 year or $10,000.00 for 2 years. Upon implementation of a federal medicare prescription drug benefit program, the annual fee shall revert to $1000.00 annually.**

E. Retail pharmacy license $300.00 bi-ennialy

F. Hospital pharmacy

license $300.00 bi-ennialy

G. Hospital drug room pursuant to Section 61-11-7 of Pharmacy Act $60.00

H. Duplicate license $10.00

I. Nonresident pharmacies $400.00 bi-ennialy

J. Seller or dispenser of contact lenses $400.00 bi-ennialy

[03-07-80...05-01-93; 16.19.12.13 NMAC - Rn, 16 NMAC 19.12.13, 03-30-02; A, 09-30-03; A, 07-15-04]

NEW MEXICO BOARD OF PHARMACY

This is an amendment to 16.19.17 NMAC Sections 5 and 7, effective 07-15-2004.

16.19.17.5 EFFECTIVE DATE: February 15, 1996, unless a [~~different~~] later date is cited at the end of a section [~~or Paragraph. This Part reformatted for inclusion into the New Mexico Administrative Code (NMAC) effective 2-15-96~~].

[02-15-96; A, 04-30-98; 16.19.17.5 NMAC - Rn, 16 NMAC 19.17.5, 03-30-02; A, 07-15-2004]

16.19.17.7 DEFINITIONS:

A. Sympathomimetic means an agent that produces effects similar to those of impulses conveyed by adrenergic fibers of the sympathetic nervous system.

B. Dangerous Drug as defined in the New Mexico Drug, Device and Cosmetic Act 26-1-2F.

(1) The following substance(s) has(have) been declared by the N.M. board of pharmacy as "Dangerous Drugs" in accordance with the Drug, Device and Cosmetic Act 26-1-18 NMSA and the Uniform Licensing Act (61-1-1 to 61-1-31 NMSA 1978). The board of pharmacy shall by regulation declare a substance a "dangerous drug" when necessary and notification shall be sent to all registered pharmacies in the state within sixty days of the adoption of the regulation. Ephedrine, USP, as ephedrine hydrochloride or ephedrine sulfate or as any other salt form**.** **[**~~as a single entity dosage form or as a compound, mixture, or preparation containing one or more additional medicinal ingredients, with each ingredient having been classified as a sympathomimetic agent in the current edition of the American Hospital Formulary Service (AHFS). Compounds, mixtures, or preparations with one or more additional active medicinal ingredients which are not classified as sympathomimetics in the current AHFS, in recognized therapeutic amounts are exempt from the above insofar as they are recognized as nonnarcotic proprietary preparations which can be lawfully sold over the counter without a prescription. In addition, any~~**]** **Any** compound, mixture, or preparation containing one-half percent (0.5%) or less of ephedrine or of any salt form of ephedrine is exempt from the above. **The following drug products containing ephedrine, USP, as ephedrine hydrochloride or ephedrine sulfate are exempted from this schedule: Bronkaid® Caplets and Primatene® Tablets. These products are exempt because they are approved for sale over the counter without a prescription under federal law, are labeled and marketed in a manner consistent with the pertinent OTC tentative final or final monograph, are manufactured and distributed for legitimate medical use in a manner that reduces or eliminates the likelihood for abuse, and are not marketed, advertised or labeled for an indication of stimulation, mental alertness, energy, weight loss, appetite control, or muscle enhancement.**

(2) A dangerous drug shall be dispensed only upon the prescription of a practitioner licensed by law to administer or prescribe such drug.

[04-19-92; 16.19.17.7 NMAC - Rn, 16 NMAC 19.17.7, 03-30-02; A, 07-15-2004]

NEW MEXICO BOARD OF PHARMACY

This is an amendment to 16.19.20.8 NMAC, effective 07-15-2004.

16.19.20.8 REGISTRATION REQUIREMENTS: Persons required to register:

A. manufacture - term includes repackagers;

B. distributors - term includes wholesale drug distributors;

C. dispensers - pharmacies, hospital pharmacies, clinics (both health and veterinarian);

D. practitioners - includes a physician, doctor of oriental medicine, dentist, physician assistant, certified nurse practitioner, clinical nurse specialist, certified nurse-midwife, veterinarian, pharmacist, pharmacist clinician, certified registered nurse anesthetists, psychologists or other person licensed or certified to prescribe and administer drugs that are subject to the Controlled Substances Act;

E. scientific investigators or researchers;

F. analytical laboratories and chemical analysis laboratories;

G. teaching institutes;

H. special projects and demonstrations which bear directly on misuse or abuse of controlled substances - may include public agencies, institutions of higher education and private organizations;

I. registration waiver: an individual licensed practitioner (e.g., intern, resident, staff physician, mid-level practitioner) who is an agent or employee of a hospital or clinic, licensed by the board, may, when acting in the usual course of employment or business, order controlled substances, for administration to the patients of the facility, under controlled substance registration of the hospital or clinic in which he or she is employed provided that:

(1) the ordering of controlled substances for administration, to the patients of the hospital or clinic, is in the usual course of professional practice and the hospital or clinic authorizes the practitioner to order controlled substances for the administration to its patients under its state controlled substance registration;

(2) the hospital or clinic has verified with the practitioner's licensing board that the practitioner is permitted to order controlled substances within the state;

(3) the practitioner acts only within their scope of employment in that hospital or clinic;

(4) the hospital or clinic maintains a current list of practitioners given such authorization and includes the practitioner's full name, date of birth, professional classification and license number, and home and business addresses and phone numbers;

(5) the list is available at all times to board inspectors, the D.E.A., law enforcement and health professional licensing boards; and

(6) the hospital or clinic shall submit a current list of authorized practitioners with each hospital or clinic controlled substance renewal application.

[16.19.20.8 NMAC - Rp 16 NMAC 19.20.8, 07-15-02; A, 12-15-02; A, 07-15-2004]

NEW MEXICO BOARD OF PHARMACY

This is an amendment to 16.19.26 NMAC, Sections 7, 8, 9, 10 & 11, effective 07-15-04.

16.19.26.7 DEFINITIONS:

A. "Antigen" means a substance recognized by the body as being foreign; it results in the production of specific antibodies directed against it.

B. "Antibody" means a protein in the blood that is produced in response to stimulation by a specific antigen.

C. "Immunization" means the act of inducing antibody formation, thus leading to immunity.

D. "Vaccine" means a specially prepared antigen, which upon administration to a person, will result in immunity.

E. "Vaccination" means the administration of any antigen in order to induce immunity; is not synonymous with immunization since vaccination does not imply success.

F. "Written protocol" means a physician's order, standing delegation order, or other order or protocol as defined by rule of the New Mexico board of pharmacy.

G. "Emergency contraception drug therapy" means the use of a drug to prevent pregnancy after intercourse.

H. "Tobacco cessation drug therapy" means the use of therapies, which may include drugs to assist in quitting any form of tobacco use.

[16.19.26.7 NMAC - N, 12-15-02; A, 07-15-04]

16.19.26.8 REFERRAL: Any pharmacist not certified to provide a prescriptive authority service is required to refer patients to a pharmacist or other provider who provides such a service.

[16.19.26.8 NMAC - N, 12-15-02; 16.19.26.8 NMAC - N, 07-15-04]

[~~16.19.26.8~~]16.19.26.9 VACCINES:

A. PROTOCOL:

(1) Prescriptive authority for vaccines shall be exercised solely in accordance with the written protocol for vaccine prescriptive authority approved by the board.

(2) Any pharmacist exercising prescriptive authority for vaccines must maintain a current copy of the protocol for vaccine prescriptive authority approved by the board.

B. EDUCATION AND TRAINING:

(1) The pharmacist must successfully complete a course of training, **accredited by the accreditation council for pharmacy education (ACPE)**, provided by: a) the centers for disease control and prevention (CDC); or b) a similar health authority or professional body [~~accredited by American Council on Pharmaceutical Education (ACPE)~~] approved by the board.

(2) Training must include study materials, hands-on training and techniques for administering vaccines, comply with current CDC guidelines, and provide instruction and experiential training in the following content areas:

(a) mechanisms of action for vaccines, contraindication, drug interaction, and monitoring after vaccine administration;

(b) standards for pediatric, adolescent, and adult immunization practices;

(c) basic immunology and vaccine protection;

(d) vaccine-preventable diseases;

(e) recommended pediatric, adolescent, and adult immunization schedule;

(f) vaccine storage management;

(g) biohazard waste disposal and sterile techniques;

(h) informed consent;

(i) physiology and techniques for vaccine administration;

(j) pre and post-vaccine assessment and counseling;

(k) immunization record management;

(l) management of adverse events, including identification, appropriate response, documentation and reporting;

(m) reimbursement procedures and vaccine coverage by federal, state and local entities.

(3) Continuing education: Any pharmacist exercising prescriptive authority for vaccines shall complete a minimum of 0.2 CEU of live ACPE approved vaccine related continuing education every two years. Such continuing education shall be in addition to requirements in 16.19.4.10 NMAC.

C. AUTHORIZED DRUGS:

(1) Prescriptive authority shall be limited to those drugs and vaccines delineated in the written protocol for vaccine prescriptive authority approved by the board and;

(2) Other vaccines as determined by the CDC or New Mexico department of health that may be required to protect the public health and safety in an established emergency.

D. RECORDS:

(1) The prescribing pharmacist must generate a written or electronic prescription for any dangerous drug authorized.

(2) Informed consent must be documented in accordance with the written protocol for vaccine prescriptive authority approved by the board and a record of such consent maintained in the pharmacy for a period of at least three years.

E. NOTIFICATION:

(1) Upon signed consent of the patient or guardian, the pharmacist shall notify the New Mexico department of health immunization program of any vaccine administered.

(2) Upon signed consent of the patient or guardian, the pharmacist shall notify the patient's designated physician or primary care provider within 15 days of any vaccine prescribed.

[16.19.26.9 NMAC - N, 12-15-02; 16.19.26.9 NMAC - Rn, 16.19.26.8 NMAC & A, 07-15-04]

[~~16.19.26.9~~]16.19.26.10 EMERGENCY CONTRACEPTION DRUG THERAPY:

A. PROTOCOL:

(1) Prescriptive authority for emergency contraception drug therapy shall be exercised solely in accordance with the written protocol for emergency contraception drug therapy approved by the board.

(2) Any pharmacist exercising prescriptive authority for emergency contraception drug therapy must maintain a current copy of the written protocol for emergency contraception drug therapy approved by the board.

B. EDUCATION AND TRAINING:

(1) The pharmacist must successfully complete a course of training, **accredited by the accreditation council for pharmacy education (ACPE)**, in the subject area of emergency contraception drug therapy provided by: a) the department of health; or b) planned parenthood or c) a similar health authority or professional body [~~accredited by the American Council on Pharmaceutical Education (ACPE)~~] approved by the board.

(2) Training must include study materials and instruction in the following content areas:

(a) mechanisms of action [~~for vaccines~~], contraindication, drug interaction, and monitoring [~~after vaccine administration~~] **of emergency contraception drug therapy**;

(b) current standards for prescribing emergency contraception drug therapy;

(c) identifying indications for the use of emergency contraception drug therapy;

(d) interviewing patient to establish need for emergency contraception drug therapy;

(e) counseling patient regarding the safety, efficacy and potential adverse effects of drug products for emergency contraception;

(f) evaluating patient's medical profile for drug interaction;

(g) referring patient follow-up care with primary healthcare provider;

(h) informed consent;

(i) record management;

(j) management of adverse events, including identification, appropriate response, documentation and reporting.

(3) Continuing education: Any pharmacist exercising prescriptive authority for emergency contraception drug therapy shall complete a minimum of 0.2 CEU of

live ACPE approved emergency contraception drug therapy related continuing education every two years. Such continuing education shall be in addition to requirements in 16.19.4.10 NMAC.

C. AUTHORIZED DRUGS:

(1) Prescriptive authority shall be limited to emergency contraception drug therapy and shall exclude any device intended to prevent pregnancy after intercourse.

(2) Prescriptive authority for emergency contraception drug therapy shall be limited to those drugs delineated in the written protocol for emergency contraception drug therapy approved by the board.

D. RECORDS:

(1) The prescribing pharmacist must generate a written or electronic prescription for any dangerous drug authorized.

(2) Informed consent must be documented in accordance with the approved protocol for emergency contraception drug therapy and a record of such consent maintained in the pharmacy for a period of at least three years.

E. NOTIFICATION: Upon signed consent of the patient or guardian, the pharmacist shall notify the patient's designated physician or primary care provider of emergency contraception drug therapy prescribed.

[16.19.26.10 NMAC - N, 12-15-02; 16.19.26.10 NMAC - Rn, 16.19.26.9 NMAC & A, 07-15-04]

16.19.26.11 TOBACCO CESSATION DRUG THERAPY:

A. PROTOCOL:

(1) Prescriptive authority for tobacco cessation drug therapy shall be exercised solely in accordance with the written protocol for tobacco cessation drug therapy approved by the board.

(2) Any pharmacist exercising prescriptive authority for tobacco cessation drug therapy must maintain a current copy of the written protocol for tobacco cessation drug therapy approved by the board.

B. EDUCATION AND TRAINING:

(1) The pharmacist must successfully complete a course of training, accredited by the accreditation council for pharmacy education (ACPE), in the subject area of tobacco cessation drug therapy provided by: a) the department of health; or b) health and human services or c) a similar health authority or professional body approved by the board.

(2) Training must include study materials and instruction in the following content areas:

(a) mechanisms of action for contraindications, drug interactions, and monitoring cessation;

(b) current standards for prescribing tobacco cessation drug therapy;

(c) identifying indications for the use of tobacco cessation drug therapy;

(d) interviewing patient to establish need for tobacco cessation drug therapy;

(e) counseling patient regarding the safety, efficacy and potential adverse effects of drug products for tobacco cessation;

(f) evaluating patient's medical profile for drug interaction;

(g) referring patient follow-up care with primary healthcare provider;

(h) informed consent;

(i) record management;

(j) management of adverse events, including identification, appropriate response, documentation and reporting;

(k) reimbursement procedures and tobacco cessation drug therapy and education coverage by federal, state and local entities.

(3) Continuing education: Any pharmacist exercising prescriptive authority for tobacco cessation drug therapy shall complete a minimum of 0.2 CEU of live ACPE approved tobacco cessation drug therapy related continuing education every two years. Such continuing education shall be in addition to requirements in 16.19.4.10 NMAC.

C. AUTHORIZED DRUGS:

(1) Prescriptive authority shall be limited to tobacco cessation drug therapy including prescription and non-prescription therapies.

(2) Prescriptive authority for tobacco cessation drug therapy shall be limited to those drugs delineated in the written protocol approved by the board.

D. RECORDS:

(1) The prescribing pharmacist must generate a written or electronic prescription for any dangerous drug authorized.

(2) Informed consent must be documented in accordance with the approved protocol for tobacco cessation drug therapy and a record of such consent maintained in the pharmacy for a period of at least three years.

E. NOTIFICATION: Upon signed consent of the patient, the pharmacist shall notify the patient's designated physician or primary care provider of tobacco cessation drug therapy prescribed.

[16.19.26.11 NMAC - N, 07-15-04]

NEW MEXICO COMMISSIONER OF PUBLIC LANDS

New Mexico State Land Office

Notice of Repealed Rule

Patrick H. Lyons, New Mexico Commissioner of Public Lands, hereby gives notice to repeal State Land Office Rule: Title 19 - Natural Resources and Wildlife, Chapter 2 - State Trust Lands, Part 10 – Easements and Rights of Way (19.2.10 NMAC), effective June 30, 2004, and that it is hereby replaced with Title 19 - Natural Resources and Wildlife, Chapter 2 - State Trust Lands, Part - 10Easements and Rights of Way (19.2.10 NMAC) effective June 30, 2004.

New Mexico State Land Office

Notice of Repealed Rule

Patrick H. Lyons, New Mexico Commissioner of Public Lands, hereby gives notice to repeal State Land Office Rule: Title 19 - Natural Resources and Wildlife, Chapter 2 - State Trust Lands, Part 15 - Relating to Contest Procedure Before the Commissioner of Public Lands (19.2.15 NMAC), effective June 30, 2004, and that it is hereby replaced with Title 19 - Natural Resources and Wildlife, Chapter 2 - State Trust Lands, Part 15 - Administrative Proceedings Before the Commissioner of Public Lands (19.2.15 NMAC) effective June 30, 2004.

NEW MEXICO COMMISSIONER OF PUBLIC LANDS

TITLE 19 NATURAL RESOURCES AND WILDLIFE
CHAPTER 2 STATE TRUST LANDS
PART 10 EASEMENTS AND RIGHTS OF WAY

19.2.10.1 ISSUING AGENCY: Commissioner of Public Lands - New Mexico State Land Office.

[19.2.10.1 NMAC - Rp, 19.2.10.1 NMAC, 06/30/04]

19.2.10.2 SCOPE: This part covers all easements and rights of way granted over, upon, through, or across, trust lands for pipelines, public highways, railroads, tramways, telegraph, fiber optic, telephone and power lines, irrigation works, mining, logging, and for other purposes,

except easements or rights of way granted in a lease, or salt water disposal easements covered by 19.2.11 NMAC, or water easements covered by 19.2.12 NMAC.
[19.2.10.2 NMAC - Rp, 19.2.10.2 NMAC, 06/30/04]

19.2.10.3 STATUTORY AUTHORITY: N.M. Const., Art. XIII; NMSA 1978 Sections 19-1-1 and 19-7-57. The authority to promulgate this part is found in Section 19-1-2 NMSA 1978.
[19.2.10.3 NMAC - Rp, 19.2.10.3 NMAC, 06/30/04]

19.2.10.4 DURATION: Permanent, unless otherwise provided in a specific section of this part.
[19.2.10.4 NMAC - Rp, 19.2.10.4 NMAC, 06/30/04]

19.2.10.5 EFFECTIVE DATE: June 30, 2004, unless a later date is cited at the end of a section.
[19.2.10.5 NMAC - Rp, 19.2.10.5 NMAC, 06/30/04]

19.2.10.6 OBJECTIVE: The objective of this part is to provide for the orderly and lawful administration and the appropriate granting of easements and rights of way on trust lands.
[19.2.10.6 NMAC - Rp, 19.2.10.6 NMAC, 06/30/04]

19.2.10.7 DEFINITIONS:

A. "Appraisal" means an appraisal as defined in Section 61-30-3A NMSA 1978.

B. "Commissioner" means the New Mexico commissioner of public lands, and his appointees under Section 19-1-7 NMSA 1978, acting within the scope of their authority. The commissioner may delegate to state land office staff the performance of functions required of the commissioner under this part.

C. "Easement" means a right or privilege granted by the commissioner, to use a defined area of trust lands for a prescribed purpose and time, which right can be terminated as provided in this part.

D. "Right of way" means a right or privilege granted by the commissioner, to pass over, upon, through, or across, a defined area of trust lands for a prescribed purpose and time, which right can be terminated as provided in this part.

E. "Fair market value" means the value that a willing buyer would pay a willing seller for a right of way or easement in the open market as set forth in a price schedule adopted by the commissioner or as otherwise determined, in the commissioner's discretion, by an appraisal or field inspection.

F. "Fee schedule" means a schedule adopted by the commissioner showing fees and costs that must be paid for performance of certain administrative functions identified in this Part 10. A fee schedule is subject to change from time to time without notice, and is available upon request. All fees, unless otherwise specified in this Part 10, shall be non-refundable.

G. "Field inspection" means an on-site inspection of a right of way or easement, made by authorized state land office personnel, which, if required under the price schedule or otherwise appropriate, may include specialized services such as market analysis or a determination of fair market value.

H. "Price schedule" means a schedule, adopted by the commissioner pursuant to this Part 10, showing the consideration due for the acquisition of an easement or right of way, which schedule shall be reviewed periodically by the commissioner and revised by him, when he deems it necessary, to reflect changes in the fair market value of easements and rights of way. A price schedule may incorporate varying considerations to account for the different uses, sizes, and locations, of easements and rights of way. The adoption of a price schedule and any revision thereof shall be preceded by reasonable public notice and the opportunity for public comment. Public notice shall consist of publication on the state land office website, and such other means as the commissioner may determine are appropriate, including but not limited to direct notification by mailing or electronic means to known interested parties. The time permitted for public comment shall be determined by the commissioner in his discretion.

I. "Purchase contract lands" means trust lands being purchased under a contract.

J. "State land office" means the New Mexico state land office.

K. "Trust" means the trust created by the New Mexico Enabling Act and administered by the commissioner.

L. "Trust lands" means those lands, their natural products and all rights, privileges, or assets, which are derived from them, and which are under the care, custody, and control of the commissioner.
[19.2.10.7 NMAC - Rp, 19.2.10.7 NMAC, 06/30/04]

19.2.10.8 NO RIGHTS TO BE OBTAINED BY PRESCRIPTION: Easements or rights of way on trust lands may be acquired only by application and grant made in compliance with this part and applicable laws. No easement, right of way, or other interest in trust lands may be acquired by prescription, or pursuant to any other legal doctrine, except as provided by statute.
[19.2.10.8 NMAC - Rp, 19.2.10.8 NMAC, 06/30/04]

19.2.10.9 TRESPASS:

A. Any use of trust lands for right of way or easement purposes prior to the grant of a right of way or easement as provided by this Part 10 shall constitute an unauthorized use of such lands and will be deemed a trespass. The use of trust lands for easement or right of way purposes, if based upon any approval by any means other than as provided for in this Part 10, will likewise be deemed a trespass. However, in extenuating circumstances and for good cause shown, the commissioner may, in his discretion and upon written request, waive the trespass penalties set out below when the trespass consists of an inadvertent failure to obtain or renew an easement or right of way and that failure is promptly corrected when discovered.

B. Upon notification or determination that an unauthorized use exists, the commissioner shall initiate criminal or civil trespass sanctions, or both, against the unauthorized user; provided, however, that prior to the initiation of such action, the commissioner may attempt to remedy the trespass non-judicially by such means as he deems best including, but not limited to: 1) offering the unauthorized user the opportunity to terminate the unauthorized use, restore the lands to their condition prior to the unauthorized use, and pay the pro-rated fair market value of the unauthorized use through the date of termination; or, 2) offering to ratify the unauthorized use upon receipt of the required consideration plus the applicable trespass penalty set forth in Subsection D of 19.2.10.9 NMAC below. The commissioner shall not initiate or otherwise pursue criminal or civil trespass sanctions against an unauthorized user if that unauthorized user accepts and complies with any non-judicial remedy offered by the commissioner to remedy the unauthorized use.

C. All time limitations imposed upon an unauthorized user by the commissioner when offering non-judicial remedies shall be reasonable, but in no case shall any such limit be less than 10 days nor more than 60 days.

D. Trespass penalties: All trespass penalties are due in addition to the consideration due under 19.2.10.15 NMAC below.

(1) An unauthorized user must pay the following trespass penalty:

(a) for the first occurrence of unauthorized use, 100% of the applicable

fair market value;

(b) for the second occurrence, 500% of the applicable fair market value;

(c) for the third occurrence, 1000% of the applicable fair market value;

(d) for the fourth and subsequent occurrences, 1000% of the applicable fair market value and the grant of easement or right of way is limited to a maximum 5-year term at the applicable fair market value for a 35-year term;

(2) Any occurrence of trespass preceded by 5 years of non-occurrence by the party in trespass will be treated as a first occurrence.

(3) In the commissioner's sole discretion, applicable trespass penalties will be reduced by no more than 50% if the trespass is self-reported before the commissioner learns of it from any other source.

(4) The trespass penalties described above apply only to unauthorized uses that commence on or after February 28, 2002. The trespass penalty for an unauthorized use that commenced prior to that date is 100% of the fair market value.

[19.2.10.9 NMAC - Rp, 19.2.10.9 NMAC, 06/30/04]

19.2.10.10 LANDS SUBJECT TO APPLICATION: An applicant must review state land office records to determine which rights, if any, have been conveyed to or contracted for by third parties, which would limit or prohibit the commissioner's issuance of additional interests. As to lands under purchase contract, see 19.2.10.29 NMAC.

[19.2.10.10 NMAC - Rp, 19.2.10.10 NMAC, 06/30/04]

19.2.10.11 SURVEY PERMISSION: Anyone desiring to apply for an easement or right of way covering trust lands shall, prior to entry for surveying activities, file with the commissioner a written notice of intent to conduct a survey of the proposed location of such easement or right of way.

A. Such written notice, which may be in letter form, shall adequately describe the proposed project, including the purpose and general location (giving section, township and range coordinates).

B. The written notice shall contain the following agreement: "The undersigned applicant indemnifies and holds harmless the commissioner, his agents and employees, and any authorized lessees of the state of New Mexico, against any and all liability for loss of life, personal injury and property damage due to survey or related activities of the applicant, or by employees, contractors or subcontractors of the applicant." In lieu of such agreement, the applicant may submit a surety bond in an amount acceptable to the commissioner.

C. Upon receipt of the notice, the commissioner shall first determine whether the requested survey is, in fact, trust lands, and if the notice and agreement are acceptable. If accepted, the applicant and any surface lessees will be notified, and the applicant will be informed of any conditions being imposed on the proposed entry by the commissioner. Failure to comply with such conditions may result in the denial of a subsequent application for a right of way or easement.

[19.2.10.11 NMAC - Rp, 19.2.10.11 NMAC, 06/30/04]

19.2.10.12 SURVEY PLAT:

A. Unless waived by the commissioner pursuant to 19.2.10.13 NMAC, each application for an easement or right of way shall include a survey plat, which describes the location (by quarter-section parts or lots, township, and range coordinates) of the proposed easement or right of way. The survey plat shall be based upon an actual survey on the ground and shall include a plat prepared in accordance with the Minimum Standards for Surveying in New Mexico as set out by the New Mexico board of registration for professional engineers and surveyors, by a professional surveyor who is registered in New Mexico or exempt from registration under the provisions of the Engineering and Surveying Practice Act, Sections 61-23-1 to -32 NMSA 1978, or its successor provisions. The survey plat shall be properly certified showing the surveyor's state of registration and registration number. The survey plat shall show the centerline of the proposed easement or right of way or, if there is no centerline, then the area of the proposed easement or right of way. The survey plat shall identify every point where the proposed easement or right of way enters or leaves state trust land, crosses a section line, fence, road, pipeline, telephone line, irrigation works, or any other visible boundary, use, or easement. The survey plat shall show the location of all improvements in the close proximity of the easement or right of way. The survey plat shall show ties to section and quarter section corners, and measurements shall be to the nearest tenth of a foot with bearings expressed to the nearest minute. In no case shall the smallest unit of angular measurement be more than one minute. Acreage shall be computed to the nearest one hundredth of an acre and the survey plat shall show the number of acres, and the number of rods, included in the proposed easement or right of way in each legal subdivision of 40 acres, more or less.

B. When the requirement to submit a survey plat in accordance with Subsection A of 19.2.10.12 NMAC has been waived pursuant to 19.2.10.13 NMAC, then the applicant must provide to the commissioner a plat (prepared by the applicant, or his designated agent), drawn to scale, and showing the location of the easement or right of way and indicating the approximate number of acres and rods to be taken, as well as the legal description (by quarter-section parts or lots, township, and range coordinates) of the lands to be burdened by the proposed easement or right of way in the form required by Subsection A of 19.2.10.12 NMAC.

[19.2.10.12 NMAC - Rp, 19.2.10.12 NMAC, 06/30/04]

19.2.10.13 APPLICATION FORM: Written application for any grant of an easement or right of way shall be made upon forms prescribed and furnished by the commissioner. Such application shall be made under oath, and contain the following:

A. the application fee set out in the then current fee schedule;

B. the field inspection fee set out in the then current fee schedule, which fee may, in the discretion of the commissioner, be waived where the applicant is a governmental body which is prohibited by law from paying fees; and,

C. a legal description of the trust lands to be burdened by the proposed easement or right of way, together with a survey plat as provided under Subsection A of 19.2.10.12 NMAC; provided, however, that the requirement to submit a survey plat in accordance with Subsection A of 19.2.10.12 NMAC may be waived, in the discretion of the commissioner, upon a showing of good cause or undue hardship; all requests for waivers, setting forth the basis of the request, must be submitted in writing to the commissioner; in the event a waiver is granted, the applicant shall comply with the requirements set forth in Subsection B of 19.2.10.12 NMAC.

[19.2.10.13 NMAC - Rp, 19.2.10.13 NMAC, 06/30/04]

19.2.10.14 TENURE: Easements and rights of way granted under this part shall be granted for a term, which the commissioner, in his discretion, deems in the best interests of the trust. Under no circumstances will the commissioner grant an easement or right of way for a perpetual term or as a fee simple grant.

[19.2.10.14 NMAC - Rp, 19.2.10.14 NMAC, 06/30/04]

19.2.10.15 CONSIDERATION:

A. For telecommunications, electric line, and pipeline easements and rights-of-way, consideration for the

grant of a right of way or easement shall be in an amount determined by the applicable price schedule unless the commissioner, in his discretion, elects to establish the price through separate field inspection or appraisal, and/or subsequent negotiation, taking into account the circumstances and damage to remaining lands; for all others, consideration shall be determined by field inspection or appraisal, and/or subsequent negotiation, or such other method as the commissioner in his discretion deems best. In each case however, unless a credit is allowed pursuant to Subsection B of 19.2.10.15 NMAC below, consideration shall not be less than the fair market value of the interest to be granted. This Section 19.2.10.15 applies to all federal, state, county, municipal, or other governmental agencies, as well as quasi-governmental bodies or organizations, as if they were private parties.

B. For gathering pipelines, salt water disposal pipelines and other pipelines not used for main transmission, the commissioner may authorize a credit of up to thirty percent (30%) of the fair market value of the interest to be granted if, after a written showing by the applicant, the commissioner, in his sole discretion, determines: 1) that the grant of an easement or right of way, with a credit, will enhance oil and gas production from trust lands; 2) that the royalties resulting from the enhanced oil and gas production will far exceed any benefits derived from receiving fair market value from the grant of easement or right of way; and 3) that granting the credit is in the best interests of the trust. If such a credit is authorized, the grantee shall pay the fair market value less the amount of the credit.

C. An applicant for an easement or right of way may apply to use an existing right of way or easement. The application must be accompanied by: a) the written consent of the existing user for the proposed second use, if different from the applicant; and b) if a discount is being requested, an appraisal, satisfactory to the commissioner, comparing the damage to trust lands that will result from the proposed easement or right of way and the damage that would be caused by that same right of way or easement if located adjacent to the proposed one. Other factors supporting a discount may be included for the commissioner's consideration. In cases where a second use is approved by the commissioner within an existing right-of-way or easement, the commissioner may, based upon the approved appraisal, and if he deems it in the best interests of the trust, discount the consideration for the second grant by no more than twenty percent (20%).

D. No applicant may have both the Subsection B of 19.2.10.15 credit and the Subsection C of 19.2.10.15 discount above. If both are applied for, the commissioner in his discretion will determine which, if any, will be allowed.

[19.2.10.15 NMAC - Rp, 19.2.10.15 NMAC, 06/30/04]

19.2.10.16 EASEMENT OR RIGHT OF WAY DIMENSIONS: The commissioner shall determine the minimum dimensions of easements and rights of way, which determinations may be changed from time to time or waived in his discretion.

[19.2.10.16 NMAC - Rp, 19.2.10.16 NMAC, 06/30/04]

19.2.10.17 ACCESS PERMITS: The rights granted by the commissioner in any right of way or easement shall not include any right of access over, or right to use, trust lands not within the actual dimensions of the right of way or easement. If a right of way or easement is not large enough to permit vehicular or other access necessary for the maintenance, repair, or improvement, of the right of way or easement, or for other permitted activities within the right of way or easement, access in such cases must be obtained by applying for and receiving a temporary access permit from the commissioner using such form or forms, and subject to the payment of such fees and costs, as the commissioner deems in the best interests of the trust and promulgates from time to time. Temporary access permits may also be issued to prospective applicants for rights of way or easements to allow them to conduct pre-application assessments. Each entry upon trust lands without an access permit as required by 19.2.10.17 NMAC shall be a separate trespass under 19.2.10.9 NMAC above.

[19.2.10.17 NMAC - Rp, 19.2.10.17 NMAC, 06/30/04]

19.2.10.18 DAMAGE SURETY:

A. The holder of an easement or right of way is required to compensate the state or its lessee, patentee, or purchase contract holder, for the reasonable value of any measurable damage done to improvements or other property, belonging to the person claiming such damages, lawfully upon the trust lands burdened by the easement or right of way. Before an easement or right of way may be issued, the applicant shall file with the commissioner a bond or other surety in an amount determined by the commissioner to be sufficient to cover such damages; provided, however, that the commissioner, in the exercise of his discretion, may waive this requirement if the applicant agrees to furnish to the commissioner, upon request, the names and addresses of its construction contractors, and if at least one of the following additional conditions is met:

(1) each lessee, patentee or purchase contract holder of the trust lands burdened by the easement or right of way provides a written waiver of this surety bond requirement; or,

(2) the applicant is a governmental agency which is prohibited by law from posting a surety bond and lawfully assumes sole and complete contractual liability for any damages arising from or in connection with its survey or use of the right of way or easement; or,

(3) the applicant is a governmental agency which is not immune from suit or is otherwise required by law to pay such damages and is thereby its own insurer, and lawfully assumes sole and complete contractual liability for any damages arising from or in connection with its survey or use of the right of way or easement; or,

(4) the commissioner, in his discretion, is satisfied that each lessee, patentee or contract holder will be afforded adequate protection other than through the posting of a bond or other surety by the applicant.

B. With the approval of the commissioner, a $25,000.00 bond, or one in any other amount that is determined by the commissioner from time to time to be in the best interests of the trust, or a different surety acceptable to the commissioner, may be used for more than one easement or right of way which the grantee has executed with the commissioner.

[19.2.10.18 NMAC - Rp, 19.2.10.18 NMAC, 06/30/04]

19.2.10.19 EXPEDITED APPLICATION: Upon the request of an applicant, satisfactorily demonstrating an emergency situation, an application for an easement or right of way may be expedited as follows:

A. If the applicant does not already have one, the application may be sent to the applicant by fax or in electronic format.

B. The applicant must complete the application and return it with an offered rental and the appropriate fees.

C. A telephonic inquiry will then be made to the appropriate state land office personnel for verbal recommendations regarding the application and the proper fee per unit to be charged.

D. After evaluating the verbal recommendation from the state land office personnel, an easement or right of way will be prepared along with a request for additional rental if necessary and faxed to the applicant.

E. Upon return of the faxed and signed notarized easement, along with payment of or an acceptable agreement to pay additional rental if requested, the

applicant will, within three days of receipt, be given verbal or fax approval.
[19.2.10.19 NMAC - N, 06/30/04]
[19.2.10.19 NMAC EXPEDITED APPLICATION is a new section added and replaces 19.2.10.19 NMAC CONSTRUCTION REPORTS. The old section headed CONSTRUCTION REPORTS is now 19.2.10.20 NMAC below]

19.2.10.20 CONSTRUCTION REPORTS: The holder of an easement or right of way shall notify the commissioner immediately when any historic or prehistoric ruin or monument, or any object of historical, archeological, or scientific value is discovered upon or within the easement or right of way. Upon such discovery, the holder of the easement or right of way shall immediately refrain from further use or disturbance of the discovery area, or any related areas where further discoveries are likely, until the commissioner has consented in writing to any further activity upon or use of the easement or right of way and notified such other authorities as the commissioner deems it in the best interests of the trust to notify.
[19.2.10.20 NMAC - Rp, 19.2.10.19 NMAC, 06/30/04]

19.2.10.21 AFFIDAVIT OF COMPLETION: Upon the completion of construction of any easement or right of way, the holder of the easement or right of way shall, within 60 days after completion of construction, file with the commissioner an affidavit of completion. Failure to file such affidavit in accordance with this section shall subject the easement or right of way to termination in accordance with the provisions of this part.
[19.2.10.21 NMAC - Rp, 19.2.10.20 NMAC, 06/30/04]

19.2.10.22 CONFLICT OF USE: Unless otherwise authorized in writing by the commissioner, an easement or right of way shall not be used for any other or additional purposes or by any other or additional parties except those expressly identified in the grant of easement or right of way. Unless expressly stated otherwise in the grant of easement or right of way, the commissioner reserves the right to grant easements or rights of way to third parties over, under, upon, through, across or parallel to an existing easement or right of way; provided, however, that the commissioner shall not approve such subsequent easements or rights of way if, in his discretion, such co-use would present a safety hazard or otherwise unreasonably interfere with the existing easement or right of way. When a subsequent easement or right of way is permitted, the commissioner will require the subsequent grantee to post a bond or other surety to insure payment of damages, if any, which are done to the prior grantee's improvements and installations unless the prior grantee waives this requirement.
[19.2.10.22 NMAC - Rp, 19.2.10.21 NMAC, 06/30/04]

19.2.10.23 AMENDMENTS: Any holder of an existing easement or right of way desiring to change the use, or widen or otherwise alter the easement or right of way shall make application to do so by following the same procedure as is used in making an application for a new easement or right of way. Depending on the scope of the proposed change to the easement or right of way, the commissioner may waive certain application requirements, such as the survey plat or the application fee.
[19.2.10.23 NMAC - Rp 19.2.10.22 NMAC, 06/30/04]

19.2.10.24 ASSIGNMENT - RELINQUISHMENT: An easement or right of way may be assigned to third parties or relinquished to the state with the prior written approval of the commissioner and upon such terms and conditions as he may prescribe, and payment of the fee set out in the then current fee schedule. The commissioner may waive the relinquishment fee when relinquishment is to accommodate a request or demand of the commissioner.
[19.2.10.24 NMAC - Rp, 19.2.10.23 NMAC, 06/30/04]

19.2.10.25 RENEWAL OF EASEMENT OR RIGHT OF WAY: Prior to the expiration date of any easement or right of way heretofore or hereafter granted for a limited term of years, an application may be submitted for a renewal of the grant. If the renewal involves no change in the location or status of the original easement or right of way, the applicant may file with the application a statement under oath setting out this fact, and the commissioner, in his discretion, may extend the grant for an additional term upon payment of such additional consideration as the commissioner determines is appropriate; provided, however, that in no case shall such consideration be less than the fair market value of the interest granted unless a credit is allowed by this part.
[19.2.10.25 NMAC - Rp, 19.2.10.24 NMAC, 06/30/04]

19.2.10.26 TERMINATION OF EASEMENT OR RIGHT OF WAY: Any easement or right of way granted by the commissioner on trust land may be terminated in whole or in part for failure to comply with any term or condition of the grant or any applicable laws or regulations. Upon determination by the commissioner that an easement or right of way is subject to termination pursuant to the terms or conditions of the grant or applicable laws or regulations, the commissioner shall give the grantee a written 30-day notice at the address shown most recently in the records of the state land office, and if the grantee fails to remedy the problems set out in the notice to the satisfaction of the commissioner, then the commissioner shall issue an appropriate instrument terminating the easement or right of way, which instrument shall be placed in the public records of the state land office with a copy to the former grantee.
[19.2.10.26 NMAC - Rp, 19.2.10.25 NMAC, 06/30/04]

19.2.10.27 ABANDONMENT: Abandonment of all or part of an easement or right of way by a grantee shall consist of the non-use of all or part of a granted easement or right of way for the purposes authorized in the granting instrument for a period of one year. Upon discovering evidence of abandonment, the commissioner shall notify the grantee by written notice sent by regular mail to the grantee's last known address as shown in the records of the state land office, giving the grantee 60 days to prove that abandonment did not occur, all to the commissioner's satisfaction. Failure to do so shall result in the termination of the easement or right of way due to the failure of a condition subsequent, and upon such termination the easement or right of way shall automatically vest in the commissioner without further action or notice required. Any non-use of a portion of an easement or right of way for a period of one year shall, at the commissioner's discretion, be deemed an abandonment of that portion so used and subject to termination.
[19.2.10.27 NMAC - Rp, 19.2.10.26 NMAC, 06/30/04]

19.2.10.28 RECLAMATION AND RESTORATION: Any person who enters upon trust lands for purposes of surveying or constructing an easement or right of way shall take all steps necessary to preserve and protect the natural environmental conditions of the land, including reclamation of disturbed areas by leveling or terracing and reasonable attempts at re-vegetation where appropriate. Re-vegetation shall include the establishment of suitable grasses and forbs in accordance with applicable state land office rules and policies. The grantee of any right of way or easement shall consult with the commissioner regarding reclamation prior to undertaking reclamation and shall make reasonable attempts at restoration.
[19.2.10.28 NMAC - Rp, 19.2.10.27 NMAC, 06/30/04]

19.2.10.29 EASEMENTS OR RIGHTS OF WAY OVER PURCHASE CONTRACT LANDS:

A. The commissioner may, on the basis of the state's legal title and subject to the terms and conditions of the applicable purchase contract, approve and record easements and rights of way over, upon, through or across purchase contract lands on the following terms and conditions:

(1) submission of an application by the easement or right of way applicant on the form prescribed by the commissioner accompanied by an original or certified copy of the easement or right of way executed between the applicant and the purchase contract holder;

(2) payment of the administrative fee set out in the then current fee schedule for the approval and recording of the easement or right of way; and,

(3) submission of a legal description of the property to be burdened by the easement or right of way, together with a survey plat as provided in 19.2.10.12 NMAC.

B. The commissioner shall reject any application and initiate necessary legal proceedings to prevent the construction of any easement or right of way or the use of any easement or right of way that will diminish or impair the state's legal title to the purchase contract lands.

[19.2.10.29 NMAC - Rp, 19.2.10.28 NMAC, 06/30/04]

19.2.10.30 INFORMAL RECONSIDERATION: Any party aggrieved by a decision related to the payment of amounts due for any easement or right of way granted or applied for under this part, may request an informal reconsideration of such decision by written request made to the commissioner. Such request shall describe the decision for which reconsideration is requested, state the grounds for reconsideration and the relief sought, and be submitted to the commissioner within 15 days after the date of the decision for which reconsideration is requested. Any such request will be reviewed and decided by the commissioner in an expeditious manner, with or without an oral presentation by the aggrieved party. The right to request informal reconsideration shall be in addition to, and not in lieu of, any right of contest available to the aggrieved party, and the filing of a request for informal reconsideration shall not extend any deadline for initiating a contest proceeding.

[19.2.10.30 NMAC - Rp, 19.2.10.29 NMAC, 06/30/04]

[The old section 19.2.10.30 NMAC PRICE SCHEDULE: TELECOMMUNICATIONS EASEMENTS AND RIGHTS OF WAY is repealed, effective 06/30/04]

HISTORY OF 19.2.10 NMAC:

Pre-NMAC History:

Material in this part was derived from that previously filed with the State Records Center and Archives under:

CPL 69-5, Rules And Regulations Concerning The Sale, Lease, And Other Disposition Of State Trust Lands, filed 09/02/69; CPL 71-2, filed 12/16/71; CPL 77-1, filed 01/07/77;

Rule 10, Relating To Easements And Rights Of Way, filed 03/11/81;

SLO Rule 10, Relating To Easements And Rights Of Way, filed 01/20/84;

SLO Rule 10, Relating To Easements And Rights Of Way, filed 08/07/85;

History of Repealed Material:

19 NMAC 3.SLO 10, Relating To Easements And Rights Of Way - Repealed, 02/28/02.

19.2.10 NMAC, Easements and Rights of Way filed 02/15/02 repealed effective 06/30/04 and replaced with 19.2.10 NMAC, Easements and Rights of Way effective 06/30/04

NEW MEXICO COMMISSIONER OF PUBLIC LANDS

TITLE 19 NATURAL RESOURCES AND WILDLIFE
CHAPTER 2 STATE TRUST LANDS
PART 15 ADMINISTRATIVE PROCEEDINGS BEFORE THE COMMISSIONER OF PUBLIC LANDS

19.2.15.1 ISSUING AGENCY: Commissioner of Public Lands, New Mexico State Land Office.

[19.2.15.1 NMAC - Rp, 19.2.15.1 NMAC, 06/30/04]

19.2.15.2 SCOPE: This part pertains to the conduct of all adjudicatory administrative proceedings before the commissioner of public lands arising from agency determinations and show cause orders, as defined herein. Contested matters arising under Section 19-10-24 NMSA 1978, and Sections 19-7-60 and 61 NMSA 1978, and certain other non-adjudicatory hearings shall not be subject to or governed by this part. This part does not enlarge, diminish or in any way alter the constitutional and statutory jurisdiction of the commissioner of public lands or the substantive rights of any person.

[19.2.15.2 NMAC - N, 06/30/04]

19.2.15.3 STATUTORY AUTHORITY: The commissioner's authority to manage the trust lands or resources is found in N.M. Const., Art. XIII, 2, and in Section 19-1-1 NMSA 1978. The commissioner's authority relative to contest proceedings is found in Sections 19-7-64 through 68 NMSA 1978 and Section 9-3-1.1 NMSA 1978. The commissioner's authority to promulgate this part is found in Sections 19-1-2 and 19-7-64 NMSA 1978.

[19.2.15.3 NMAC - N, 06/30/04]

19.2.15.4 DURATION: Permanent.

[19.2.15.4 NMAC - N, 06/30/04]

19.2.15.5 EFFECTIVE DATE: June 30, 2004, unless a later date is cited at the end of a section.

[19.2.15.5 NMAC - Rp, 19.2.15.5 NMAC, 06/30/04]

19.2.15.6 OBJECTIVE: The objective of this Part 15 is to provide a clear, mandatory, administrative remedy for persons aggrieved by an agency determination or show cause order, as defined herein, and to provide rules to govern the conduct of the adjudicatory administrative proceedings, all within the scope of this Part 15.

[19.2.15.6 NMAC - N, 06/30/04]

19.2.15.7 DEFINITIONS:

A. "Agency determination" means a written determination, by the commissioner or his designee, regarding a final action or decision taken by him through a state land office department or division, which action adversely and materially affects a person's right, title, interest or priority of claim in or to trust lands or resources, and which arises from, or in connection with, a lease, contract, easement, right of way, grant, conveyance, or any other instrument executed by the commissioner or his designee.

B. "Commissioner" means the commissioner of public lands, or a person fully authorized to act in his stead. References to the commissioner as a participant in the contest proceedings shall mean the state land office department or division responsible for the agency determination at issue, or on behalf of which, a show cause order is issued.

C. "Contest" means the administrative hearing at which a decision of the commissioner, as defined herein, is made regarding a show cause notice of the commissioner or a petition contesting an agency determination.

D. "Contest notice" means notification of the occurrence or denial of a contest issued by the comissioner.

E. "Decision of the commissioner" means the final decision rendered by order of the commissioner at the conclusion of a contest pursuant to this Part

15. A decision of the commissioner as such is any "decision" "ruling" or "order" under Chapter 19, NMSA 1978 appealable to a district or higher court, including any such decision of the commissioner so referred to in Sections 19-7-8, 19-7-17, 19-7-67, 19-10-22, and 19-10-23 NMSA 1978. A decision of the commissioner is the "final decision or order of an agency" as used in Rules of Civil Procedure for the District Court, Rule 1-074C NMRA 2004. A decision of the commissioner is a "final decision" as that term is used in Section 39-3-1.1H(2) NMSA 1978.

F. "Hearing officer" means the person appointed by the commissioner to conduct the contest.

G. "Petitioner" means the person initiating a contest by petition; in the case of a show cause proceeding there will be no petitioner.

H. "Respondent" means any party to a contest initiated by petition, other than the petitioner or the commissioner; in the case of a show cause proceeding the person(s) to whom the show cause order is directed shall be the respondent(s).

I. "Scheduling order" means an order issued by the hearing officer that sets the date, time and place of the contest; establishes the order and timing of all pre-hearing matters, such as discovery and briefing; may establish whether procedures in addition to those provided for in this Part 15 shall be provided; and may provide for such other related matters as the hearing officer deems necessary. Under appropriate circumstances, the scheduling order may be amended by the hearing officer within a reasonable time after issuance.

J. "Show cause order" means an order issued by the commissioner, pursuant to Section 19-7-8 NMSA 1978 or otherwise as may be permitted, directing a party or parties to show cause, if any, why a particular agency action should not be taken or made final. The show cause order will state the place and time of the contest hearing. A show cause order is an agency determination.

K. "Trust lands or resources" means those lands, their natural products or water rights, and other assets derived from them, which are under the care, custody, and control of the commissioner.

[19.2.15.7 NMAC - N, 06/30/04]

19.2.15.8 AGENCY DETERMINATION:

A. A contest will not be initiated by petition without the petitioner first having received an agency determination. In the case of a contest initiated by the commisioner's show cause order, the order itself is the agency determination, and no petition is necessary.

B. An agency determination may be rendered at any time deemed appropriate by the commissioner or his designee, or may be rendered, if deemed appropriate by the commissioner, upon request of an interested party.

C. An agency determination will be rendered in writing, shall be dated, and will be provided to the affected party or parties, or to their agent, representative, or successor, in written or electronic format by such means as can reasonably provide verification of receipt. It shall be sufficient if an agency determination is provided to the physical or electronic address most recently shown in the public records of the commissioner.

D. An agency determination will state that it will become non-appealable unless the party to whom it is directed initiates a contest proceeding or responds to the show cause order pursuant to this Part 15 within thirty (30) days of the date of the agency determination, or within such other longer time as fairness and circumstances may, in the commissioner's discretion, require.

E. A demand, offer, or any other agency decision or act, which is still open to negotiation or change by the commissioner, is not an agency determination.

[19.2.15.8 NMAC - N, 06/30/04]

19.2.15.9 CONTEST:

A. Right to contest. Subject to Subsection B of 19.2.15.9 NMAC below, any persons or entities aggrieved by an agency determination shall have the right to a contest pursuant to this Part 15. Such proceedings are a mandatory administrative remedy and must be completed before recourse to any court is available.

B. Limitation of right. Unless the commissioner in his discretion determines otherwise, a contest shall not involve matters which would not require the presence of the commissioner as a necessary party in a district court proceeding. The right of a party to initiate a contest proceeding is not a waiver of any defense or claim by the commissioner or any other party regarding threshold matters such as jurisdiction, sovereign immunity, standing, ripeness, mootness, failure to state a claim, and the like.

C. Contest participants. In the case of a contest initiated by a show cause order, the participants shall be the commissioner and the respondent. In the case of a contest initiated by petition, the contest participants shall be the commissioner, the petitioner, and any respondents. The hearing officer may, in his discretion, permit third parties to intervene or to participate as amicus curae. All pleadings shall contain a certificate indicating that all other participants have been served with a copy of the pleading by first-class mail or by such other means as the hearing officer may allow.

D. Representation. Contest particpants may represent themselves, or may be represented by counsel to the same extent allowed in the district courts of New Mexico. Parties who represent themselves will be held to the same standards of conduct and pleading as if they were represented by counsel.

E. Location. All contests shall, at the sole discretion of the commissioner, be held either at the offices of the New Mexico state land office in Santa Fe, New Mexico, or at any other location deemed most expedient by the commissioner.

[19.2.15.9 NMAC - Rp, 19.2.15.9 NMAC, 06/30/04]

19.2.15.10 INITIATING A CONTEST:

A. By written petition. Subject to the hearing officer's ability to allow amendment of the petition for failure to comply with the requirements of form set out below when it appears to him the petition sets out a good faith claim, a contest shall be initiated by written petition, sent by certified or registered mail to the commissioner, which shall contain the following:

(1) As set out in the example (2) below, the caption shall designate the subject matter in reference to the lease, contract, easement, right of way, grant, conveyance, or other instrument which forms the basis of the petitioner's claims.

(2) The caption will also designate the petitioner by full name as such, then the respondent, if any, shall be designated by full name as such. A place should be provided for the proceeding to be numbered. The title shall be bolded and underlined. In the case of a contest over a grazing lease, for example, the caption should appear as follows:

Before the Commissioner of Public Lands

In Re State Land Office Grazing Lease No. GX-0000
Mr. And Mrs. A.B., petitioner
v

Contest No. _____

X. Corp., respondent

Petition for Contest

(3) the name, mailing and e-mail addresses, telephone and fax numbers of the petitioner and of each respondent in the contest proceeding;

(4) a legible copy of the instrument or instruments which form the basis of the claim in issue;

(5) the aliquot description, by subdivision, section, township and range, of the land or lands in issue;

(6) a concise, complete statement of the claim or claims of the petitioner;

(7) a concise, complete statement of the facts giving rise to the claim or claims in issue;

(8) a statement of the relief being requested as to each claim; and

(9) a sworn statement that a copy of the "foregoing petition" has been sent to the commissioner
and to all respondents by registered or certified mail, and the date when sent.

B. By show cause order. A contest may be initiated by the commissioner's show cause order sent by certified or registered mail. The show cause order shall contain the following:

(1) As set out in the example (2) below, the caption shall designate the subject matter in reference to the lease, contract, easement, right of way, grant, conveyance, or other instrument which forms the basis of the commissioner's claims.

(2) The caption will also designate the respondent by full name as such. The title shall be bolded and underlined. A place should be provided for the proceeding to be numbered. In the case of a show cause order issued in connection with a business lease for example, the caption should appear as follows:

Before the Commissioner of Public Lands

In Re State Land Office Business lease No. BL-0000

Contest No. _____

X Corp., respondent

Show Cause Order

To Mr. A.B., for X Corporation, respondent;

(3) the name, mailing and e-mail addresses, telephone and fax numbers of the respondent;

(4) a legible copy of the instrument or instruments which form the basis of the show cause order;

(5) the aliquot description, by section, township and range, of the land or lands in issue;

(6) a concise, complete statement of the basis of the show cause order;

(7) a concise, complete statement of the facts giving rise to the show cause order;

(8) a statement of the final decision proposed by the commissioner; and

(9) a statement that a copy of the show cause order has been sent to the respondent by registered
or certified mail, and the date when sent.

C. In the case of a contest initiated by a petition, within 10 days of the receipt of a contest petition, the commissioner will give, to the petitioner and any identified respondents, a contest notice stating whether the petition sets out sufficient cause for contest within the scope of this Part 15. The commissioner may reject a contest petition because the requisite agency determination has not been obtained, because the petition states a clearly spurious claim, because the petition is filed as an abuse of process, or because the matters alleged are too complex for an administrative determination or involve too many or unrelated parties. An adverse contest notice, one denying the petition, is an appealable decision of the commissioner. In the case of a contest initiated by show cause order, the show cause order itself shall be the contest notice.

D. Within 30 days of the date of the written notice in Subsection C of 19.2.15.10 NMAC above, each respondent shall submit to the commissioner, also by certified mail, a response, in the form provided for in Paragraph (2) of Subsection A or Paragraph (2) of Subsection B of 19.2.15.10 NMAC above, which shall set forth:

(1) the name, mailing and e-mail addresses, and telephone and fax numbers of each person or entity whom it is believed should be included in the contest, if not already named, and a statement of the basis for such belief;

(2) legible copies of any other instruments that are thought to be relevant to the contest;

(3) a concise, complete statement of the defenses to the claim, of what it is believed should be the disposition of the petitioner's claim, and of any additional cross-claim or counter-claim to be made in connection with the same issues and the relief being requested;

(4) a concise, complete statement of any relevant, additional facts not offered by the petitioner(s) in their petition or not offered by the commissioner in the show cause order; and

(5) a summary of the arguments and authorities supporting the defenses or claims.

E. Subject to the hearing officer's ability to allow amendment of the response for failure to comply with the requirements of form set out above when it appears to him that the response is made in good faith, failure to respond, within the time and in the form required in Subsection D of 19.2.15.10 NMAC above, without having first obtained an extension of time to do so by written request directed to and granted by the commissioner, will be deemed a default, and will result in the issuance of a decision of the commissioner.

F. Upon concurrence of the parties, or upon his own determination that circumstances require it, the commissioner may shorten or lengthen the times allowed.

[19.2.15.10 NMAC - N, 06/30/04]

19.2.15.11 HEARING OFFICER:

A. Following receipt of the acceptable contest petition, the commissioner shall, by order, appoint a hearing officer to preside over the adminstrative hearing. As soon as practicable, the hearing officer shall issue a scheduling order. In his discretion, the commissioner may appoint a designated person from within the state land office who has not participated in the agency determination.

B. The commissioner's appointment of a hearing officer shall constitute a delegation of the commissioner's statutory powers under Section 19-7-65 NMSA 1978 and of the commissioner's constitutional and inherent power to control the conduct of administrative proceedings under the commissioner's jurisdiction.

C. *Ex parte* communication with the hearing officer is strictly prohibited.

[19.2.15.11 NMAC - N, 06/30/04]

19.2.15.12 PRE-HEARING DISCOVERY, CONFERENCES, AND MOTION PRACTICE:

A. Pursuant to the scheduling order, the parties to the contest and the

commissioner shall provide one another and the hearing officer with a written summary of their arguments and authorities, as well as complete lists of all witnesses (including a summary of their testimony) and all exhibits (including a brief summary of what each exhibit will be offered to prove, and a summary of its contents). Such lists shall be promptly updated as evidence and witnesses are added or deleted. Each party and the commissioner shall within forty-five (45) days after the receipt of the petition by the commissioner, or upon such longer period as the hearing officer may allow, produce to all parties and the commissioner all documents related to the matters in controversy, or that are reasonably calculated to lead to the discovery of relevant and material evidence, or that the party intends to offer at the hearing. All parties and the commissioner shall supplement their production within ten (10) days of discovering documents that meet the foregoing criteria. The scheduling order or other order of the hearing officer may provide such additional discovery as the hearing officer deems fair and appropriate. It is expected that all such discovery shall proceed without the necessity of any request being made to the hearing officer. The hearing officer shall have the right to preclude any testimony or other evidence which, in his opinion, has not been fairly and reasonably disclosed before the hearing.

(1) Any party or the commissioner, if dissatisfied with discovery, may request, in writing, that the hearing officer order another party to provide better or additional discovery. The opposing party shall respond within such time as the hearing officer establishes. The hearing officer may, in his or her discretion, allow oral argument on discovery disputes.

(2) Discovery orders of the hearing officer are not appealable, but may form the basis of an appeal of the decision of the commissioner in the matter.

B. Upon his own initiative, or at the request of the commissioner, or a petitioner or respondent, the hearing officer may, in his discretion, require scheduling, settlement, or such other conferences at the principal offices of the state land office, or at any other location deemed best by the hearing officer.

C. Pursuant to the scheduling order, the hearing oficer may permit or limit such motions, responses, and replies as are normally permitted in the state district courts of New Mexico. Except as set out herein, any procedures regarding such motion practice shall be established by the hearing officer on his own or at the request of the commissioner or the parties. As to motions which dispose of all or part of the merits of any claim at issue, the hearing officer shall make a recommendation by written report to the commissioner who shall make a final determination. Except in rare cases and for good cause shown, the disposition of any motion is not subject to interlocutory appeal; the disposition of any motion is appealable only when the contest is concluded by a decision of the commissioner.

[19.2.15.12 NMAC - N, 06/30/04]

19.2.15.13 WITNESSES:

A. Within such time as the hearing officer etablishes in the scheduling order, each party may obtain from the hearing officer a subpoena for the attendance of all material witnesses at depositions or hearings. Consistent with applicable law or court rules, the hearing officer may charge a fee for the issuance of each such subpoena, and may establish fees for the attendance of witnesses.

B. The hearing officer may, on his own or at the request of any party or the commissioner, exclude witnesses for the hearing during the testimony of other witnesses or at any other time deemed proper or expedient.

C. All witnesses shall testify under oath.

D. The hearing shall proceed as scheduled without the attendance of a witness or a party if no prior notification of absence and request for an extension of time was received.

E. The testimony of a witness or party unable to attend may be preserved by deposition. The hearing officer may, if he deems it helpful, accept affidavits of witnesses unable to attend, but will weigh their probative value as such.

[19.2.15.13 NMAC - Rp, 19.2.15.14 NMAC, 06/30/04]

19.2.15.14 HEARING PROCEDURE:

A. In conducting the hearing, the hearing officer shall refer to, but shall not be bound by, the then current distict court rules regarding procedure and evidence. Evidence not admissable under those rules may be admitted by the hearing officer if he reasonably believes such admission will help in providing or clarifying relevant facts without substantially prejudicing the rights of any party. In particular, hearsay evidence may be admitted by the hearing officer, but shall not form the sole basis for his recommendations. The hearing officer may require any evidence to be submitted in writing. Decisions of the hearing officer regarding matters of evidence or procedure are not, in themselves, final or appealable decisions, but may form the basis for appealing a decision of the commissioner.

B. There shall be a formal written record of a contest. The commissioner shall, at the time of apointment of a hearing officer, appoint a state land office employee to act as the hearing officer's clerk, who shall receive and file all elements of the record. The hearing officer shall designate a court reporter to record the hearing.

C. Unless otherwise indicated by the hearing officer, the order of proceedings shall be as follows:

(1) In a case initiated by a show cause order, the commissioner shall present his case first: opening statements by the commissioner, the respondent(s), and any intervenors, in that order; presentation of evidence by the commissioner in support of the validity of the proposed action or actions forming the basis of the show cause order; presentation of evidence by the respondent(s) in support of the status quo; and presentation of evidence by any intervenors in support of their position, in that order; and closing arguments by the commissioner, the respondent, and any intervenors, in that order.

(2) In a contest initiated by petition, the petitioner shall present his case first:opening statements by the petitioner, the respondent, any intervenors, and the commissioner, in that order; presentation of evidence in support of any defense, claim, or counterclaim and any rebuttal evidence by the petitioner, the respondent, any intervenors, and the commissioner, in that order; and closing arguments by the petitioner, respondent, any intervenors, and the commissioner, in that order.

D. At any point in the contest hearing, the hearing officer may initiate questions, may request that the commissioner, petitioner(s) or respondent(s) provide briefing on an issue or take any other action deemed necessary to expedite the proceeding and to obtain a full understanding of the facts and the issues.

E. In a contest initiated by a show cause order, there shall be no initial burden of proof, and the recommendation of the hearing officer shall be based on a preponderance of the evidence supporting either the action or actions proposed to be taken by the commissioner, or supporting the status quo prior to the issues raised in the show cause order. In a contest initiated by petition, the burden of proof shall be upon any party asserting a claim, cross claim, or counterclaim, and the recommendation of the hearing officer shall be based upon a preponderance of the evidence offered in support or rebuttal of any such claim, cross claim, or counterclaim.

[19.2.15.14 NMAC - N, 06/30/04]

19.2.15.15 COSTS AND FEES:

A. Each participant in a contest proceeding, excluding the commissioner, shall be required, upon their first filing, to pay a non-refundable filing and processing fee of fifty dollars ($50.00).

B. Contest participants requiring copies from the commissioner shall be required to pay a copy fee in the amount then set out in the applicable policy or other written statement governing such costs.

C. At the earliest practicable date, the hearing officer shall obtain from each participant in the contest an estimate of time needed to present their part of the proceeding. Based on such estimates, the hearing officer will determine the cost of prducing a record of the proceedings, and, if applicable, the fee or salary for the hearing officer's time to conduct the proceeding. At any time prior to or following the hearing, the hearing officer may determine that additional costs are necessary if it becomes evident that more time has been, or will be required to conclude the proceeding. Each party will be required to pay, as a deposit, the amount of all costs assessed by the hearing officer in order to attend the proceeding and to have their arguments and evidence considered.

(1) A party who prevails upon all issues shall be entitled to the return of their full deposit. If they prevail in part, their deposit shall be returned in proportion to the number of claims, counterclaims, and cross claims upon which they prevailed.

(2) The deposit amount remaining after a return of funds to the prevailing party, or parties, shall be first applied to all applicable costs, with the balance of each deposit returned to each losing party in proportion to the number of claims, counterclaims or cross claims upon which they did not prevail.

(3) The determination of the proportions set out in paragraphs one (1) and two (2) above shall be discretionary with the hearing officer.

D. The hearing officer may, upon a satisfactory showing of inability to pay on the record, permit that party to proceed with reduced or no costs, and absorb those unpaid costs, to the extent not covered by a retained deposit, as an administrative expense.

E. Each party shall bear their own costs and fees in bringing or defending a contest.

[19.2.15.15 NMAC - N, 06/30/04]

19.2.15.16 ALTERNATIVE DISPUTE RESOLUTION: At any time during the pendency of a contest proceeding, the parties or the commissioner may, by agreement, and upon providing written notice of the agreement to the hearing officer, elect to use any form of alternative dispute resolution. Upon receipt of such notice, the hearing officer will, as required by the agreement of the parties, terminate or stay any further actions or proceedings. Any final result achieved through alternative dispute resolution shall, if agreed to by the parties and the commissioner, be made binding on all by a decision of the commissioner and shall be non-appealable except as otherwise provided by law.

[19.2.15.16 NMAC - N, 06/30/04]

19.2.15.17 DECISION OF THE COMMISSIONER:

A. At the conclusion of the hearing, all parties and the commissioner shall leave with the hearing officer such items of evidence as he requires.

B. At the conclusion of the hearing, the hearing officer may require such post-hearing pleadings and submissions as he deems appropriate.

C. At the conclusion of the hearing, the hearing officer shall indicate the time within which a final report shall be made.

D. The hearing officer's final report shall be provided to all parties and to the commissioner.

E. Upon receipt of the hearing officer's final report, the commissioner shall, within a reasonable time, issue an order adopting, modifying, or rejecting that report. This order shall be the decision of the commissioner, and as such, it shall contain a grant or denial of the relief requested and a statement of the legal and factual basis for the order.

F. The decision of the commissioner will be filed in the lease file or other pertinent official record of the New Mexico state land office.

G. Each party, and each other person who has requested a copy, shall, after the decision of the commissioner is filed, be provided with a copy of the decision of the commissioner along with a statement of the requirements for appealing the the order.

[19.2.15.17 NMAC - Rp, 19.2.15.15 NMAC, 06/30/04]

19.2.15.18 APPEAL:

A. Appeal of the commissioner's decision in a contest shall be as provided in Section 39-3-1.1 NMSA 1978. In such an appeal, the appealing party shall be named as appellant, and the commissioner and other parties shall be named as appellees. The style of such appeal shall be, for example in the case of a contest over a grazing lease, *In Re State Land Office Grazing Lease GX-0000.*

B. Failure to perfect an appeal of a decision of the commissioner within the time allowed by and pursuant to Section 39-3-1.1 NMSA 1978 results in that decision becoming final, binding and non-appealable.

[19.2.15.18 NMAC - Rp, 19.2.15.16 NMAC, 06/30/04]

HISTORY OF 19.2.15 NMAC:

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

CPL 69-5, Rules and Regulations Concerning the Sale, Lease, and Other Disposition of State Trust Lands, filed 09/02/69;

CPL 71-2, filed 12/16/71;

CPL 77-1, filed 01/07/77;

Rule 15, Relating to Contest Procedures Before the Commissioner of Public Lands, filed 03/11/81.

SLO Rule 15, Relating to Contest Procedures Before the Commissioner of Public Lands, filed 01/20/84.

History of Repealed Material:

19.2.15 NMAC Relating to Contest Procedure Before the Commissioner of Public Lands filed 12/02/02, repealed effective 06/30/04 and replaced with 19.2.15 NMAC Administrative Proceedings Before the Commissioner of Public Lands, effective 06/30/04.

NEW MEXICO COMMISSION OF PUBLIC RECORDS

TITLE 1 GENERAL GOVERNMENT ADMINISTRATION
CHAPTER 13 PUBLIC RECORDS
PART 6 NEW MEXICO HISTORICAL RECORDS SCHOLARSHIP PROGRAM GUIDELINES

1.13.6.1 ISSUING AGENCY: New Mexico Commission of Public Records - New Mexico Historical Records Advisory Board (NMHRAB).

[1.13.6.1 NMAC - N, 06/30/04]

1.13.6.2 SCOPE: Eligible applicants include state, county, municipal and Native American government repositories; non-profit organizations; and qualified individuals. See 1.13.5.8 NMAC.

[1.13.6.2 NMAC - N, 06/30/04]

1.13.6.3 STATUTORY AUTHORITY: Public Records Act, Chapter 14, Article 3 NMSA 1978 and 44 U.S.C.25, 36CFR1206, CFDA Section 89.003.

[1.13.6.3 NMAC - N, 06/30/04]

1.13.6.4 DURATION: Permanent.
[1.13.6.4 NMAC - N, 06/30/04]

1.13.6.5 EFFECTIVE DATE: June 30, 2004, unless a later date is cited at the end of a section.
[1.13.6.5 NMAC - N, 06/30/04]

1.13.6.6 OBJECTIVE: The NMHRAB has received funds from the New Mexico legislature and the national historic publications and records commission (NHPRC) to fund its historical records scholarship programs for improving preservation of and access to New Mexico's historical records. To address funding issues that underlie many other problems identified during its strategic planning process, the NMHRAB created its grant scholarship program. Subject to funding availability, scholarships shall be awarded annually to applicants who demonstrate need, financially and programmatically, and show commitment to solving their historical records problems. Training sessions shall support funding priorities of the NMHRAB as published.
[1.13.6.6 NMAC - N, 06/30/04]

1.13.6.7 DEFINITIONS:

A. "Access" means the availability of archives, records or manuscripts in terms of physical condition, legal permission and intellectual entry.

B. "Non-profit organization" means any organization, which by its articles of association and by-laws prohibits acts of private inurement, that is, transferring of the organization's earnings to persons in their private capacity; non-profit organizations are required to use their earnings for their program activities and these earnings are tax-exempt if the organization has met the approval of the internal revenue service as falling within a category such as 501(c) (3).

C. "Original records" means archives or public records as created by a governmental or quasi-governmental body, and manuscripts such as letters, diaries, photographs or other first-hand reports.

D. "Preservation" means the provision of adequate facilities for the protection, care and maintenance of archives, records and manuscripts, particularly to promote their future availability.

E. "Sponsoring organization" means a governmental or non-profit organization that employs the applicant.
[1.13.6.7 NMAC - N, 06/30/04]

1.13.6.8 ELIGIBILITY:

A. To be eligible for a historical records scholarship, the applicant shall be employed by or volunteer for one of the following.

(1) A governmental organization including:

(a) state agencies as prescribed in the Public Records Act;

(b) public schools;

(c) district courts;

(d) public colleges and universities and all associated programs;

(e) county offices;

(f) municipal offices;

(g) quasi-governmental organizations; or

(h) Native American government organizations.

(2) A non-profit organization; verified as such by:

(a) a copy of its tax-exempt or 501(c)(3), or equivalent, status and

(b) evidence that it has made provisions for the transfer of their holdings to a like organization or an appropriate repository upon dissolution.

B. Previous scholarship recipients shall be in compliance with the stipulations of all previous awards in order to continue to be eligible.
[1.13.6.8 NMAC - N, 06/30/04]

1.13.6.9 TYPES OF SCHOLARSHIPS FUNDED: The NMHRAB will award grants to cover the cost of training and a percentage of travel to attend either in-state or out-of-state training in archives and records management principles and practices as defined in the annual announcement of availability of scholarship funds.
[1.13.6.9 NMAC - N, 06/30/04]

1.13.6.10 FUNDING:

A. At least ten percent, but not less than $1,500 of available historical records grant program funds shall be set aside for archives and records management training scholarships.

B. The scholarship grant shall cover the cost of training and 80 percent of travel costs at New Mexico state mileage and per diem rates as established in 2.42.2 NMAC.

C. Subject to funding availability the NMHRAB shall award grants to successful applicants up to the annual cap. Should additional funds become available, the board may award grants to those who met the criteria but were not funded because of cap limits or may issue a subsequent call for applications.

D. The board may reduce the pre-established cap amount if the amount requested by eligible applicants is less than the pre-established cap. Any reduction shall be added to the funds available for historical records grants.
[1.13.6.10 NMAC - N, 06/30/04]

1.13.6.11 APPLICATION FOR HISTORICAL RECORDS SCHOLARSHIPS:

A. A New Mexico historical records advisory board scholarship application shall be completed in its entirety.

B. The application shall contain a description of the original, permanent or historical records holdings of the sponsoring organization, how training will benefit the sponsoring organization or the records and demonstrate financial need for the scholarship.

C. The applicant shall provide a letter of support from the management of the sponsoring organization.

D. A minimum match shall be required from the eligible entity and applicant of 20 percent of travel costs.

E. Rejection: Applications that do not comply with these criteria shall be rejected.
[1.13.6.11 NMAC - N, 06/30/04]

[Obtain an application by calling (505) 476-7936, faxing a request to (505) 476-7893, or by e-mailing a request to nmhrab@rain.state.nm.us. Refer to the NMHRAB web page at http://www.nmcpr.state.nm.us/nmhrab for additional information about available resources.]

1.13.6.12 REVIEW PROCESS: Scholarship applications shall be subject to the following review process.

A. All applicants shall be screened for eligibility by the NMHRAB grant administrator.

B. The NMHRAB scholarship committee shall award scholarships up to the established annual cap except as provided in Subsection D of 1.13.6.10 NMAC. The committee shall notify the full NMHRAB of the results at its next regular meeting.
[1.13.6.12 NMAC - N, 06/30/04]

1.13.6.13 POST AWARD REQUIREMENTS:

A. Submit proof of training, including:

(1) a copy of a certificate issued upon completion of the training and

(2) all receipts for appropriate travel expenses (mileage, lodging, etc.).

B. Submit an article to the NMHRAB office for possible publication in agency newsletter, the Quipu or other publications.
[1.13.6.13 NMAC - N, 06/30/04]

HISTORY OF 1.13.6 NMAC: [RESERVED]

NEW MEXICO COMMISSION OF PUBLIC RECORDS

This is an amendment to 1.13.2 NMAC, Sections 10, 11, 12 and 14.

1.13.2.10 ACID-FREE ARCHIVAL STORAGE CONTAINERS:

A. Document storage box 15 ¼ in. x 10 ¼ in. x 5 in. - $[~~3.00~~] 3.15

B. Document storage box 15 ¼ in. x 10 ¼ in. x 2 in - $[~~2.95~~] 3.10

C. Record storage box 15 in. x 12 in. x 10 in. - $[~~3.80~~] 4.00

D. Full telescope box 15 in. x 11 ½ in. x 3 in. - $[~~4.85~~] 5.15

E. Full telescope box 24 ½ in. x 20 ½ in. x 3 in. - $[~~6.35~~] 6.70

F. Clam shell box 15¼ in. x 10 ¼ in. x 3 ½ in. - $[~~3.05~~] 3.30

G. Newspaper box 25 in. x 19 in. x 2 ½ in. - $[~~9.25~~] 7.95

H. Legal size folder full tab package (100 count) - $[~~20.55~~] 21.75

I. Letter size folder full tab package (100 count) - $[~~18.00~~] 19.10

J. Corrugated board, 40 in. x 60 in. sheet - $[~~6.20~~] 6.60

K. Other containers - containers of sizes other than those listed above may be available at cost plus five percent.

[1.13.2.10 NMAC - N, 3/14/01; A, 04/30/02; A, 06/30/04]

[Please contact the Archives and Historical Services Division at 505-476-7956 for the availability and prices of the other containers noted in Subsection K.]

1.13.2.11 PHOTOCOPY FEES:

A. Paper photocopies.

(1) 8 ½ x 11 (1 to 99 copies) - $0.25

(2) 8 ½ x 11 (100 to 499 copies) - $0.40

(3) 8 ½ x 11 (500 or more copies) - $0.55

(4) 8 ½ x 14 (1 to 99 copies) - $0.30

(5) 8 ½ x 14 (100 to 499 copies) - $0.45

(6) 8 ½ x 14 (500 or more copies) - $0.60

(7) 11 x 17 (1 to 99 copies) - $0.35

(8) 11 x 17 (100 to 499 copies) - $0.50

(9) 11 x 17 (500 or more copies) - $0.65

B. Certified paper photocopies.

(1) 8 ½ x 11 (1 to 99 copies) - $ 0.50

(2) 8 ½ x 11 (100 to 499 copies) - $0.80

(3) 8 ½ x 11 (500 or more copies) - $1.00

(4) 8 ½ x 14 (1 to 99 copies) - $0.60

(5) 8 ½ x 14 (100 to 499 copies) - $0.90

(6) 8 ½ x 11 (500 or more copies) - $1.00

(7) 11 x 17 (1 to 99 copies) - $0.70

(8) 11 x 17 (100 or more copies) - $1.00

C. Self-service photocopies (made by patron).

(1) 8 ½ x 11 - $[~~0.15~~] 0.10

(2) 8 ½ x 14 - $[~~0.15~~] 0.10

(3) 11 x 17 - $[~~0.35~~] 0.15

D. Oversized maps and drawings.

(1) 12 x 18 - $3.35

(2) 17 x 22 - $3.40

(3) 18 x 24 - $3.35

(4) 22 x 34 - $3.40

(5) 24 x 36 - $3.45

(6) 30 x 42 - $3.50

(7) 32 x 44 - $3.90

(8) 36 x 48 - $4.10

(9) Sizes greater than 36 x 48 add $1.00 per foot to $4.10.

E. Fax copies - $0.60

[7/1/95, 1/1/98, 9/15/98; 1.13.2.11 NMAC - Rn, 1 NMAC 3.100.9.1 through 1 NMAC 3.100.9.4 and 1 NMAC 3.100.13 & A, 3/14/01; A, 06/30/04]

1.13.2.12 MICROPHOTOGRAPHY FEES:

A. Microfilm to paper copies.

(1) 8 ½ x 11 - $0.50

(2) 8 ½ x 14 - $0.60

B. Self-service microfilm to paper copies.

(1) 8 ½ x 11 - $0.10

(2) 8 ½ x 14 - $0.10

(3) 11 x 14 - $0.15

C. Microfilm duplication - agency masters.

(1) 16mm - $11.00 per reel

(2) 35mm - $12.00 per reel

D. Microfilm duplication services - archival collections.

(1) 16mm - $12.00 per reel

(2) 35mm - $16.00 per reel

E. Compact disk duplication services - archival collections.

(1) Land records of New Mexico (Spanish archives of New Mexico I - [~~(~~]SANM I) - $1,250.00

(2) Spanish archives of New Mexico II (SANM II) - $250.00

(3) Translations - $125.00

(4) Mexican archives of New Mexico (MANM) - $725.00

(5) Territorial archives of New Mexico (TANM) - $7,340.00

(6) Sender Collection - $50.00

F. Microfilm processing. 16mm and 35mm - $19.85 per reel

[7/1/95, 9/15/98, 12/15/98; 1.13.2.12 NMAC - Rn, 1 NMAC 3.100.10 & A, 3/14/01; A, 04/30/02; A, 06/30/04]

[Of the items listed under Subsection E, above, only the *Translations* are available as of April 2002; others are scheduled for completion in Fiscal Years 2003 through 2005. Also, item costs cited under Subsection E are for the collections. For costs for partial collections, see 1.13.2.17 NMAC, *Electronic Copies of Records*.]

1.13.2.14 SRCA PUBLICATIONS:

A. Calendar to the Spanish archives of [~~NM~~] New Mexico II - $10.00

B. Calendar to the Mexican archives of [~~NM~~] New Mexico - $6.00

C. Calendar to the territorial archives of [~~NM~~] New Mexico - $6.00

D. Calendar to land [~~grant~~] records of New Mexico (Spanish archives of New Mexico I) - $10.00

E. Calendar to the Sender collection - $12.00

F. Guide to "lost" records of Zuni - $7.00

G. Microfilm manual - $18.50

H. Genealogy charts - $3.50

I. New Mexico administrative code training manual - extra copies (individuals attending training receive one copy of the manual without charge) - $22.50

J. Billy the Kid packet - $37.80

K. Guide to the archdiocese of Santa Fe: the AASF and LDS series - $7.00

L. New Mexico county marriage register inventory - $7.00

M. Picture postcards - $5.00

[7/1/95, 9/15/98, 12/15/98; 1.13.2.14 NMAC - Rn, 1 NMAC 3.100.12 & A, 3/14/01; A, 04/30/02; A, 7/15/03; A, 06/30/04]

NEW MEXICO COMMISSION OF PUBLIC RECORDS

This is an amendment to 1.13.5 NMAC, Sections 2, 6, 7, 8, 9, 10, 11, 12, 13 14, 15, 16 and 17, effective June 30, 2004.

1.13.5.2 SCOPE: Eligible applicants include state, county, municipal, and Native American government repositories; non-profit organizations; and qualified individuals. See 1.13.5.8 NMAC.

[1.13.5.2 NMAC - N, 11/30/00; A, 06/30/04]

1.13.5.6 OBJECTIVE: The NMHRAB has received funds from the New Mexico legislature and the national historic publications and records commission (NHPRC) to fund its historical records grant programs for improving preservation of and access to New Mexico's historical records. To address funding issues that underlie many other problems identified during its strategic planning process, the NMHRAB created its grant program. Subject to funding availability, grants [~~will~~] shall be awarded annually to applicants who demonstrate need, financially and programmatically, and show commitment to solving their historical records problems. Projects [~~must~~] shall address the funding priorities of the NMHRAB as published.

[1.13.5.6 NMAC - N, 11/30/00; A, 06/30/04]

1.13.5.7 DEFINITIONS:

A. "Access" means the availability of archives, records or manuscripts in terms of physical condition, legal permission, and intellectual entry.

B. "Accession" means a term used as both a noun and a verb for the act and procedures involved in a transfer of legal title and the taking of records or papers into the physical custody of an archival agency, records center or manuscript repository and the materials involved in such a transfer.

C. "Archives" means the non-current records of an organization or institution preserved because of their continuing value in meeting the needs of the creating organization.

D. "Archivist" means an employee whose duty is to maintain the non-current records of an organization or agency in order to serve its needs. [~~A degree or certification in archival management~~] Evidence of advanced study in an applicable academic area is usually required.

E. "Arrangement of collections" means the process and results of organizing [~~archives,~~] records or manuscripts, particularly by function or activity of their creator.

F. "Collection policy" means a statement adopted by an archival agency, records center or manuscript repository to guide its accessioning and de-accessioning decisions in order to carry out its formal mission.

G. "Cubic feet" means a standard measure of the quantity of archival material; the term refers to the amount of space usually occupied by one standard records storage box (12 in. x 12 in. x 16 in.) on standard archival shelving. By conversion, 36 inches of letter-size papers, arranged lineally (three linear feet), would occupy approximately two cubic feet, if placed in storage boxes.

H. "Curator" means an employee whose duty is to foster research by making accessible order of a repository's collections. [~~A degree or certification in library management~~] Evidence of advanced study in an applicable academic area is usually required.

I. "De-accession" means the act, or the materials involved in the act, of a transfer out of the custody of an archives and is the opposite of accession.

J. "Documentary edition" means a published edition of documents derived directly from original records and often accompanied by editorial commentary and annotations.

K. "Essential minimum" means, in the interests of efficiency and economy, the most succinct statements and the most definitive examples that meet the application requirements, thus keeping the proposal package simple, focused and relevant. [~~resumes, for example, are more impressive by their relevance than by their length~~] For example, resumes, which provide the essential minimum, are more impressive by their relevance than by their length.

L. "Evaluation" means a mechanism by which the effectiveness of the project can be measured by describing the extent to which a project's goals have been met. Narrative, graphic or statistical methods can be used to assess the product or to analyze the process. Participant or user assessments are also helpful in some cases.

M. "Finding aid" means a descriptive device created by an archives, records center or repository to establish the size, condition, content or arrangement of a collection or record group.

N. "Fiscal agent" means the financial representative of a corporation or service organization, or the officer authorized to make financial transactions.

O. "Mission statement" means a [~~formally~~] formal, written statement of an organization's or agency's purpose or vision. Non-profit organizations normally provide a mission statement when registering with the New Mexico public regulation commission.

P. "Non-profit organization" means any organization, which by its articles of association and by-laws prohibits acts of private inurement, that is, transferring of the organization's earnings to persons in their private capacity; non-profit organizations are required to use their earnings for their program activities and these earnings are tax-exempt if the organization has met the approval of the internal revenue service as falling within a category such as 501(c) (3).

Q. "Original records" means archives or public records as created by a governmental or quasi-governmental body, and manuscripts such as letters, diaries, photographs or other first-hand reports.

R. "Preservation" means the provision of adequate facilities for the protection, care and maintenance of archives, records, and manuscripts, particularly to promote their future availability.

S. "Provenance" means the source or the office of origin of the records and thus the principle of maintaining the integrity of the records' identity by their creator and, also, respect for their original order.

T. "Qualified individuals" means an archivist, curator, librarian or records manager.

U. "Records manager" means an employee whose duty is to manage the creation, use and disposition of an organization or agency's records [~~; a degree or certification in records management~~]. Evidence of advanced study in an applicable academic area is usually required.

V. "Statement of need" means a logical and succinct presentation of the argument for the necessity of a project [~~which~~]; it should be factual, reasonable and persuasive.

[1.13.5.7 NMAC - N, 11/30/00; A, 06/30/04]

1.13.5.8 ELIGIBILITY:

A. To be [~~an~~] **eligible** [~~**entity**~~] for an historical records grant, the

applicant shall be one of the [~~following:~~] entities listed below.

(1) [~~a~~] A governmental organization including:

(a) state agencies as prescribed in the Public Records Act;

(b) public schools;

(c) district courts;

(d) public colleges and universities and all associated programs;

(e) county offices;

(f) municipal offices;

(g) quasi-governmental organizations [~~and~~]; or

(h) Native American government organizations.

(2) [~~a~~] A non-profit organization, verified as such by:

(a) [~~verified by presenting~~] a copy of its tax-exempt or 501(c)(3), or equivalent, status and

(b) [~~shall submit~~] evidence that it has made provisions for the transfer of [~~their~~] its holdings to a like organization or an appropriate repository upon dissolution;

(3) [~~a~~] A qualified individual including:

(a) an individual affiliated with or consulting with an eligible entity[~~; and~~] or

(b) an individual registered with the state as a business whose work will result in documentary editions or will benefit historical records repositories generally, and whose credentials meet the standards set by the NMHRAB.

[~~**B.** To be eligible for a scholarship, the applicant shall be employed by, or volunteer for, an eligible entity.~~

~~**C**~~**]** **B.** Previous [~~awardees~~] grant recipients shall be in compliance with the stipulations of all previous awards in order to continue to be eligible.

[1.13.5.8 NMAC - N, 11/30/00; A, 09/30/02; A, 07/15/03; A, 06/30/04]

1.13.5.9 CONDITIONS FOR RECEIVING A HISTORICAL RECORDS GRANT:

A. The applicant shall demonstrate financial need and [~~that it is prepared~~] the ability to carry out the objective of the proposal within the grant period.

B. The applicant shall describe the records covered by the proposal and their importance in documenting New Mexico's history.

C. The applicant shall have custody of, or consult with organizations that have custody of, historically significant original records.

D. Records treated in the proposed project shall be made available for public research unless specific exemption is granted by the NMHRAB. Proposals submitted by tribal governments, for example, may be excluded from this criterion.

E. An affected organization shall be committed to sound archival practices, as demonstrated through its collection policy or a statement from its governing body indicating its commitment to:

(1) support of the project and

(2) [~~the~~] continuation of the project's purposes beyond the grant period.

F. A person qualified by credentials or training to carry out the objectives of the proposed project shall supervise the project. If this requirement is not met at the time the proposal is submitted, the proposal shall include provisions for attending NMHRAB-sponsored or NMHRAB-approved training totaling at least 24 clock hours before the project's proposed start date, unless otherwise approved by the NMHRAB.

G. Organizations shall have a mechanism for evaluating the impact of the project on their historical records' [~~environment~~] environments.

[1.13.5.9 NMAC - N, 11/30/00; A, 09/30/02; A, 07/15/03; A, 06/30/04]

1.13.5.10 FUNDING PRIORITIES: Grant funds shall be ranked according to funding priorities adopted by the NMHRAB.

A. Training programs or opportunities for historical records' custodians to develop basic management tools for the care and preservation of records in their custody.

B. Assessment or survey of records that are in public and private repositories that results in developing or enhancing a repository's records or archival management program.

C. Development of tribal records management and archival programs.

D. Identification and mitigation of at-risk historical records in public and private repositories (activities may include preservation and conservation processes needed to stabalize the media on which records are captured in accordance with an approved conservation plan).

E. Preservation activities that include but are not limited to reformatting (microfilm, copying to permanent media, etc)[~~,~~] and re-housing.

F. Projects that facilitate access to New Mexico's historical records through activities that include but are not limited to cataloging, creating finding aids, digitizing (shall include an appropriate index) and organizing collections.

G. Documentary research based on original records that [~~result~~] results in publication or dissemination.

H. Programs that promote New Mexico's history through its historical records with activities that include exhibits, conferences, papers and documentaries.

[1.13.5.10 NMAC - N, 11/30/00; 07/15/03; A, 07/15/03; A, 06/30/04]

1.13.5.11 TYPES OF PROJECTS FUNDED:

A. [~~All worthy projects will be considered. Preference will be given to those projects that~~] Projects shall directly address the funding priorities published in the NMHRAB strategic plan. Funding priorities are published in order of importance. Following are examples of projects that could be funded.

(1) Consultations that effect an improvement in the preservation of, management of or access to historical records, through assessment resulting in a strategic plan for the repository, by providing training in archival methods and techniques or records management principles and techniques, or by establishing an archival or records management program. Consultants [~~must~~] shall be competent in the area in which they plan to consult as demonstrated by their credentials or training.

(2) Program development projects that establish or elevate standards of archival or records management practice in the applicant repository.

(3) Model training programs that focus on developing tools and strategies that can be used to train staff in more than one repository [~~or repeatedly in high turnover situations~~] or in a repository experiencing high-turnover.

(4) Preservation projects that mitigate unstable or deteriorating conditions of historical records through the identification, organization and description, conservation treatment or reformatting of the records - for example, copying to another medium, such as microform.

(5) Access projects that promote the availability of historical records by developing finding aids. Examples include: indexing significant collections; creating electronic catalog records or distributing collection guides; [~~automating~~] providing on-line access to finding aids; digitizing historical records; and placing copies in other repositories that have agreed to accept them.

(6) Research projects that provide original scholarly exposition or interpretation of documentary evidence of New Mexico history based on original records, and documentary edition projects that publish original records for general usage. Since these projects are a lower funding priority, proposals [~~must~~] shall be very well developed if funding is to be obtained.

B. Projects proposing collaborative efforts to address specific record keeping or preservation issues will be given additional consideration.

[~~C. Scholarships~~. ~~The NMHRAB will award grants to cover the cost of training and travel to attend either in state or out of state training in archives and records management principles and practices as defined in the annual announcement of availability of scholarship funds.~~]
[1.13.5.11 NMAC - N, 11/30/00; A, 09/30/02; A, 06/30/04]

1.13.5.12 EXCLUSIONS:

A. Grants cannot be used to replace organization budgets for staff, but grant funds can be used to hire temporary staff. Grant funds cannot be used to acquire software or equipment, or to pay the indirect costs of the applicant. However, staff committed by the organization to the project and equipment and software purchased specifically for the project can be used as in-kind match.

B. Consultant fees funded by the grant may not exceed $45.00 per hour. Related travel expenses shall be within state of New Mexico allowable rates. (See Per Diem and Mileage Act)

C. Proposals for digitization projects [~~are~~] shall be acceptable only if they take into consideration the issue of migration to newer technologies. Microfilming projects shall be justified on the basis of the volume of original records, the demand for usage or the risk of loss of their content.
[1.13.5.12 NMAC - N, 11/30/00; A, 07/15/03; A, 06/30/04]

1.13.5.13 FUNDING:

[~~A.~~] The NMHRAB has funding annually to divide among successful applicants. Minimum awards of $500 and maximum awards of $8,500 per applicant are possible [~~, with a funding cycle cap of [$5,000] up to $8,500 per applicant~~], depending on available funds. Applicants shall provide a minimum match valued at 25 percent of the total cost of their projects in either cash or in-kind services or materials. Preference [~~will~~] shall be given to proposals that match the grants with 50 percent cash or in-kind. The in-kind [~~must~~] match shall be rendered during the project period.

[~~B. At least ten percent, but not less than $1,500 of available funds shall be set aside for archives and records management training scholarships.~~

~~(1) The scholarship grant covers the cost of training and travel at New Mexico state mileage and per diem rates as established in 2.42.2 NMAC. Scholarships shall be granted to cover 80 percent of travel needed to attend training.~~

~~(2) The NMHRAB shall award grants to successful applicants up to the annual cap. Should additional funds become available, the Board may award grants to those who met the criteria but were not funded because of cap limits; or may issue a subsequent call of applications.~~

~~(3) The board may reduce the pre-established cap amount if the amount requested by eligible applicants is less than the pre-established cap. Any reduction will be added to the funds available for historical record grants.~~]
[1.13.5.13 NMAC - N, 11/30/00; A, 09/30/02; A, 07/15/03; A, 06/30/04]

1.13.5.14 APPLICATION FOR HISTORICAL RECORDS GRANTS:

A. An applicant shall [~~complete~~] answer all questions on the application form. An applicant may submit pertinent attachments to support its application, but the number of pages shall be limited to the essential minimum. An applicant shall submit one completed application with original signatures and supporting documents, and eight copies. Incomplete applications [~~cannot~~] shall not be considered.

B. The following information shall be included in the application.

(1) Applicant information - legal [~~entity's~~] name, address, contact name, phone number and e-mail address.

(2) [~~Applicant's signature~~] Signature by an individual authorized to obligate the [~~legal entity~~] applicant.

(3) Fiscal agent's name, title and address.

(4) Project title, period and amount of both the grant request and the proposed match.

(5) Applicant's status [~~shall be established by identifying the qualifying organization. An applicant or individual must~~]:

(a) An organization shall be an eligible entity as defined in Subsection A of 1.13.5.8 NMAC.

(b) An individual shall be legally affiliated with the qualifying organization or repository[~~,~~] and professionally engaged in work applicable to the historical records community [~~, and~~]; or registered as a business [~~with~~] within the state of New Mexico whose work will result in documentary editions or will benefit historical records repositories generally, and whose credentials meet the standards set by the NMHRAB.

(6) A copy of the organization's formally adopted statement of mission or purpose.

(7) A copy of the organization's collection management policy (unless establishing one is the objective of the proposal).

(8) A summary statement that briefly summarizes the nature and purpose of the project proposed for funding no more than one-quarter page in length.

(9) A project description narrative limited to three pages in length. The narrative shall discuss content and significance of the historical records to be affected by this project, the scope of the work to be performed, key personnel and the work plan for the project.

(10) The budget for the project [~~shall be~~] submitted on the form prescribed by the NMHRAB.

C. Project period: Funded projects [~~must~~] shall be completed [~~in~~] within one year from date specified in award letter.

D. Application deadline: Completed applications (original and eight copies) [~~must~~] shall be received by the deadline set forth in the call for proposals [~~by the NMHRAB chair~~].

E. Rejection: Applications that do not comply with these criteria [~~will~~] shall be rejected.
[1.13.5.14 NMAC - N, 11/30/00; A, 09/30/02; A, 07/15/03; A, 06/30/04]

1.13.5.15 [~~APPLICATION FOR ARCHIVES AND RECORDS MANAGEMENT TRAINING SCHOLARSHIPS:~~

~~**A.** A New Mexico historical records advisory board scholarship application shall be completed in its entirety.~~

~~**B.** The application shall contain a description of the permanent or historical records holdings of the eligible entity, how training will benefit the organization or the records, and demonstrate financial need for the scholarship.~~

~~**C.** The applicant shall provide a letter of support from the management of the eligible entity.~~

~~**D.** A minimum match is required from the eligible entity and applicant of cost of training and 20 percent of travel costs.~~

~~**E.** Rejection: Applications that do not comply with these criteria will be rejected.~~] [RESERVED]
[1.13.5.15 NMAC - N, 11/30/00; renumbered to 1.13.5.16 NMAC, 09/30/02. 1.13.5.15 NMAC - N, 09/30/02; A, 07/15/03; Repealed, 06/30/04]

1.13.5.16 REVIEW PROCESS:

[~~A.~~] **Historical records grant applications** [~~will~~] shall be subjected to a three-stage review process.

[~~(1)~~] A. First, all applications [~~will~~] shall be screened for eligibility and compliance with the guidelines. Organizations [~~who~~] that have submitted ineligible and non-compliant applications [~~will~~] shall be notified by the NMHRAB administrative office.

[~~(2)~~] B. Second, all applications [~~will~~] shall be reviewed for technical merit

on an established rating system by New Mexico state records center and archives professional staff, and recommendations for further consideration made. At this level applicants [~~will~~] shall be advised of points that may need clarification or elaboration in order to enhance a proposal's viability.

[~~(3)~~] C. Third, recommended proposals [~~will~~] shall be evaluated by the NMHRAB and ranked according to published priorities at the regular [~~October~~] fall meeting.

[~~**B. Scholarship applications** will be subjected to the following review process.~~

~~**(1)** All applicants will be screened for eligibility by the NMHRAB grant administrator.~~

~~**(2)** The NMHRAB scholarship committee will award scholarships up to established annual cap. The Committee shall notify the full NMHRAB of the results at it's next regular meeting.~~]

[1.13.5.16 NMAC - N, 11/30/00; Rn to 1.13.5.17 NMAC, 09/30/02. 1.13.5.15 Rn to 1.13.5.16, & A, 09/30/02; A, 07/15/03; A, 06/30/04]

1.13.5.17 POST-AWARD REQUIREMENTS:

[~~A.~~] Successful historical record grant applicants shall comply with the following post award requirements.

[~~(1)~~] A. Submit progress reports halfway through the project.

[~~(2)~~] B. Submit final reports within 60 days of project completion.

[~~(3)~~] C. Request funds on a reimbursement basis and no more than 50 percent before substantial completion of the work.

[~~(4)~~] D. Submit proof of completion of training before project start date, if required.

[~~(5)~~] E. Adhere to the State Procurement Code for purchase of goods and services.

[~~(6)~~] F. Maintain grant records for at least two years after completion of the project.

G. Submit an article to the NMHRAB office for possible publication in agency newsletter, the Quipu or other publication.

[~~**B.** Scholarship recipients will submit proof of training:~~

~~**(1)** copy of registration form and confirmation;~~

~~**(2)** copy of attendance sheet;~~

~~**(3)** copy of certificate issued upon completion of the training; and~~

~~**(4)** a copy of the registration form marked as paid and copy of check paying for the training.~~]

[1.13.5.16 NMAC Rn to 1.13.5.17 NMAC, & A, 09/30/02; A, 06/30/04]

NEW MEXICO COMMISSION OF PUBLIC RECORDS

This is an amendment to 1.15.2 NMAC GRRDS General Administrative Records, Sections 303 and 307, effective July 15, 2004.

1.15.2.303 ELECTRONIC MAIL:

A. Program: electronic records

B. Maintenance system: agency preference

C. Description: [~~electronically transmitted information (including graphics) of a transitory nature. (If electronic mail system is being utilized to transmit documentation (i.e., correspondence, memoranda, etc.) other than of transitory nature (i.e., administrative procedural or policy), then print or file off and retain for required length of time for specific document.~~] electronic mail is electronic messaging for delivering text, graphical, audio, or multimedia content. Electronic mail messages generally consist of a header, a message, and on occasion attachments. The header contains information about the source and the route the message took from sender to recipient, which is ignored by normal users, but may contain technical information relevant to information systems staff.

D. Retention: [~~until no longer needed for reference but no longer than 30 days after date created~~]

(1) E-mail with transitory informational value: until no longer needed for reference but no longer than 30 days after date sent or received

(2) E-mail records with established retention value: refer to retention periods set for those records in the records retention and disposition schedule for the agency including the general records retention and disposition schedules (administrative, personnel, financial). These schedules have already been developed and filed by the SRCA.

E. Methodology for e-mail disposition:

(1) E-mail with transitory informational value: E-mail considered to have transitory informational value may be disposed of when information communicated no longer has any informational value. When informational value ends, e-mail user (sender, recipient) may transfer these communications along with their attachments to a destroy bin and to be destroyed per 1.13.3 NMAC Management of Electronic Records and 1.13.30 NMAC Destruction of Public Records.

(2) E-mail records with established finite retention value: E-mail communiqués (messages) considered to have informational value because they pertain to or are of records with established retention value including permanent, may be printed and filed off to the appropriate paper file or may be filed off to electronic folders (removed from inbox) and disposed of when they have met their established legal retention per Destruction of Public Records 1.13.30 NMAC. [The] information system administrator with the assistance and guidance of e-mail users shall create these folders outside the e-mail system based on a filing system that reflects the records retention and disposition schedule for the agency including the general schedules (administrative, personnel, financial). When the legal retention value for these records [electronic folders] has been met, the assigned records liaison officer for the agency with the assistance of the e-mail user (sender, recipient) may transfer these communications along with their attachments to a destroy bin to be destroyed per 1.13.3 NMAC Management of Electronic Records and 1.13.30 NMAC Destruction of Public Records.

(3) E-mail records with permanent retention value: permanent-archival records on electronic media shall be maintained by the custodial agency or transferred to the NM archives per Section 13 of 1.13.3 NMAC Management of Electronic Records.

(4) Purging the e-mail system: The information systems administrator shall purge the e-mail system of all active (inbox) communiqués that are older than 30 days per 1.15.2.303 *electronic mail*, 1.13.3 NMAC Management of Electronic Records, and 1.13.30 NMAC Destruction of Public Records.

[Rn, 1 NMAC 3.2.90.10.30.A303, 12-30-98; 1.15.2.303 NMAC - Rn, 1 NMAC 3.2.90.10.A303, 10/01/2000; A, 1/6/2002; A, 07/15/2004]

1.15.2.307 PUBLICATIONS:

A. Program: public relations

B. Maintenance system: chronological by publication date

C. Description: printed work regardless of format or method of reproduction published by any state agency or political subdivision for distribution and that is produced by the authority of or at the total or partial expense of a state agency or is required to be distributed under law by the agency; and is publicly distributed outside the agency by or for the agency.

D. Retention:

(1) Publications filed with the state library per Section 18-2-4.1 NMSA 1978:

(a) Agency's copy: until superseded or until information no longer needed for reference

(b) State library's copy: permanent

(c) State archive's copy: permanent

(2) All other publications: transfer to archives for review and final disposition

[1.15.2.307 NMAC - N, 07/15/2004]

[For filing publications with the state library refer to 1.25.10.9 NMAC.]

NEW MEXICO COMMISSION OF PUBLIC RECORDS

This is an amendment to 1.17.218 NMAC, Sections 1, 2, 3, 6, 7, 8, 9, 101 - 110, 121 - 124, 131 - 134, and 141 - 143, effective July 3, 2004.

TITLE 1 GENERAL GOVERNMENT ADMINISTRATION
CHAPTER 17 J U D I C I A L RECORDS RETENTION AND DISPOSITION SCHEDULES (JRRDS)
PART 218 JRRDS, NEW MEXICO MAGISTRATE COURTS

1.17.218.1 ISSUING AGENCY: New Mexico Commission of Public Records - State Records Center and Archives in conjunction with the New Mexico Supreme Court.

[5-25-95; 1.17.218.1 NMAC - Rn, 1 NMAC 3.2.92.1, 1-6-02; A, 7-3-04]

1.17.218.2 SCOPE: [~~All courts - judicial~~] New Mexico magistrate courts

[5-25-95; 1.17.218.2 NMAC - Rn, 1 NMAC 3.2.92.2, 1-6-02; A, 7-3-04]

1.17.218.3 AUTHORITY:

[~~A.~~ ~~Judicial records retention committee established.~~

~~B.~~ ~~Judicial records retention committee, duties.~~

~~(1) The committee shall establish a records management program for the application of efficient and economical management methods to the creation, utilization, maintenance, retention, preservation and disposal of official records.~~

~~(2) The committee shall establish records disposal schedules for the orderly retirement of records. Records disposal schedules shall be filed with the NM state records center and archives, rules division, and shall not become effective until a NM supreme court order has been issued.~~] Section 14-3-1 NMSA 1978. The state records administrator shall establish records disposal schedules for the orderly retirement of records in compliance with the Public Records Act.

[5-25-95, 5-19-97; 1.17.218.3 NMAC - Rn, 1 NMAC 3.2.92.3, 1-6-02; A, 7-3-04]

[Amendment of this rule may require the issuance of a court order.]

1.17.218.4 D U R A T I O N : Permanent

[5-25-95, 5-19-97; 1.17.218.4 NMAC - Rn, 1 NMAC 3.2.92.4, 1-6-02]

1.17.218.5 EFFECTIVE DATE: May 19, 1997 unless a different date is cited at the end of a section.

[5-25-95, 5-19-97; 1.17.218.5 NMAC - Rn, 1 NMAC 3.2.92.5, 1-6-02]

1.17.218.6 OBJECTIVE:

[~~A.~~ ~~To establish a records management program for the application of efficient and economical management methods to the creation, utilization, maintenance, retention, preservation and disposal of official records (Section 14-3-6 NMSA 1978).~~

~~B.~~ ~~To establish records disposal schedules for the orderly retirement of records and adopt regulations necessary for the carrying out of the Public Records Act (Section 14-3-6 NMSA 1978).~~] To establish a records disposal schedules for the orderly management and retirement of records necessary for carrying out the Public Records Act per 14-3-6 NMSA 1978.

[5-25-95, 5-19-97; 1.17.218.6 NMAC - Rn, 1 NMAC 3.2.92.6, 1-6-02; A, 7-3-04]

1.17.218.7 DEFINTIONS:

A. "Administrator" means the state records administrator. (Section 14-3-2, NMSA 1978)

B. "Agency" means any state agency, department, bureau, board, commission, institution or other organization of the state government, the territorial government and the Spanish and Mexican governments in New Mexico. (Section 14-3-2, NMSA 1978)

C. "Audit" means a periodic examination of an organization to determine whether appropriate procedures and practices are followed.

D. "Commission" means the state commission of public records. (Section 14-3-2, NMSA 1978)

E. "Note bene" stands for information important for the administration of the retention period.

[~~E.~~] F. "Pending litigation" means a proceeding in a court of law whose activity is in progress but not yet completed.

[~~F.~~] G. "Record destruction" means the process of totally obliterating information on records by any method to make the information unreadable or unusable under any circumstances.

[~~G.~~] H. "Records management" means the systematic control of all records from creation or receipt through processing, distribution, maintenance and retrieval, to their ultimate disposition.

[~~H.~~] I. "Records retention period" means the period of time during which records must be maintained by an organization because they are needed for operational, legal, fiscal, historical or other purposes.

[~~I.~~] J. "Records retention schedule" means a document prepared as part of a records retention program that lists the period of time for retaining records.

[~~J.~~] K. "Public records" means all books, papers, maps, photographs or other documentary materials, regardless of physical form or characteristics, made or received by any agency in pursuance of law or in connection with the transaction of public business and preserved, or appropriate for preservation, by the agency or its legitimate successor as evidence of the organization, functions, policies, decisions, procedures, operations or other activities of the government, or because of the informational and historical value of data contained therein. (Section 14-4-2, NMSA 1978)

[~~K.~~] L. "Non-records" library or museum material of the state library, state institutions and state museums, extra copies of documents reserved only for convenience of reference and stocks of publications and processed documents are non-records. (Section 14-3-2 C NMSA 1978). The following specific types of materials are non-records: extra copies of correspondence; documents preserved only for convenience of reference; blank forms/books which are outdated; materials neither made nor received in pursuance of statutory requirements nor in connection with the functional responsibility of the officer/agency; preliminary and non-final drafts of letters; reports and memoranda which may contain or reflect the working or deliberative process by which a final decision or position of the agency, board, department or subdivision thereof is reached: shorthand notes, steno tapes, mechanical recordings which have been transcribed, except where noted on agency retention schedules; routing and other interdepartmental forms which are not significant evidence of the activity concerned and do not otherwise have value as described above; stocks of publications already sent to archives and processed documents preserved for supply purposes only; form and guide letters, sample letters, form paragraphs; subject files, including copies of correspondence, memoranda, publications, reports and other information received by agency and filed by subject (also referred to

as reading files or information files). See also item number 1.15.2.101 NMAC of record retention and disposition schedule for general administrative records.
[5-25-95, 5-19-97; 1.17.218.7 NMAC - Rn, 1 NMAC 3.2.92.7, 1-6-02; A, 7-3-04]

1.17.218.8 ABREVIATIONS AND ACRONYMS:

A. "AOC" stands administrative office of the courts.

B. "DWI" also stands for driving while impaired.

C. **"**GRRDS" stands for general records retention and disposition schedule.

D. "JRRDS" stands for judicial records retention and disposition schedule.

E. "FACTS" stands for *family automated client tracking system*.
[1.17.218.8 NMAC - N, 7-3-04]

1.17.218.9 INSTRUCTIONS:

A. For records of a general administrative nature, refer to the [~~Records Retention and Disposition Schedule for the General Administrative Records, 1.15.2 NMAC~~] GRRDS, Records Retention and Disposition Schedule for the General Administrative Records, (For Use by Local Government and Educational Institutions) 1.15.3 NMAC.

B. [~~For records of a financial nature, refer to the Records Retention and Disposition Schedule for General Financial Records, 1.15.4 NMAC~~.] For records of a financial nature, refer to the GRRDS, General Financial Records Retention and Disposition Schedule (Interpretive), 1.15.5 NMAC. The magistrate court does not voucher through the New Mexico department of finance and administration but rather through the business office of the AOC. The retentions for financial documents held by the AOC business office are identified as "finance department copy." The retentions for financial documents held by the magistrate court business office are identified as "other department copy".

C. [~~For records of a personnel nature, refer to the Records Retention and Disposition Schedule for the General Personnel Records, 1.15.6 NMAC~~.] For records of a personnel nature, refer to the GRRDS, General Personnel Records Retention and Disposition Schedule (Interpretive), 1.15.7 NMAC. Employment at the magistrate court does not go through the New Mexico state personnel office but rather through the human resources office of the AOC. The retentions for personnel documents held by the AOC human resource office are identified as "personnel department copy." The retentions for personnel documents held by the magistrate court human resource office are identified as "other department copy.

D. For records of medical nature, refer to the Records Retention and Disposition Schedule for the General Medical Records, 1.15.8 NMAC.

E. Retention periods shall be extended until six months after all current or pending litigation, current claims, audit exceptions or court orders involving a record have been resolved or concluded.

F. The descriptions of files are intended to be evocative, not complete; for example, there will always be some documents that are filed in a file that are not listed in the description, and similarly, not every file will contain an example of each document listed in the description.

G. [~~Confidentiality is denoted as " C ". Not all materials in a file may be confidential. Refer to NOTE. Where portions of file may be confidential, refer to legal counsel for agency.~~] Confidentiality is denoted for files likely to contain confidential materials, but files without a confidentiality note nonetheless may contain confidential or privileged materials and failure to include an express confidentiality note in the description of a file does not waive the confidential or privileged nature of those materials. Refer questions concerning the confidentiality of a file or portions of a file to legal counsel for the agency.

H. Access to confidential documents and or confidential files shall be only by authorization of agency or attorney general and or by court order, unless otherwise provided by statute. Release of confidential documents to law enforcement and other government agencies, shall only be upon specific statutory authorization or court order.

I. All records, papers or documents may be photographed, microfilmed, micro-photographed or reproduced on film. Such photographs, microfilms, photographic film or microphotographs shall be deemed to be an original record for all purposes, including introduction in evidence in all courts or administrative agencies. (Section 14-1-5, 14-1-6 NMSA 1978)

J. [~~Data processing and other machine readable records~~.] Electronic records. Many paper records are being eliminated when the information has been placed on magnetic tapes, disks, or other data processing media. In these cases, the information on the data processing medium should be retained for the length of time specified in records retention and disposition schedules for paper records and should be subject to the same confidentiality and access restrictions as paper records. When the destruction of a record is required, all versions of said record shall be electronically over-written on machine readable media on which it is stored (or media destroyed). See also 1.13.70 NMAC: Performance Guidelines for the Legal Acceptance of Public Records Produced by Information Technology Systems.
[5-25-95, 5-19-97; 1.17.218.9 NMAC - Rn, 1 NMAC 3.2.92.8, 1-6-02; A, 7-3-04]

1.17.218.10 - 1.17.218.100 [RESERVED]

1.17.218.101 COURT AGENDA:

A. Program: general records

B. Maintenance: chronological by setting date

C. Description: record by day of settings in the court. Record shows court date, judges, violation date, citation number, defendant name, docket number, etc.

D. Retention: 30 days after scheduled court date
[5-11-94, 1-10-97, 5-19-97; 1.17.218.101 NMAC - Rn, 1 NMAC 3.2.92.218.03.101, 1-6-02; A, 7-3-04]
[NOTE: court agenda is also known as docket call or court calendar.]

1.17.218.102 [~~COURT CLERK CASE LOAD SUMMARY REPORT, MONTHLY:~~

~~A. Program:~~ ~~general records~~

~~B. Maintenance:~~ ~~chronological~~

~~C. Description:~~ ~~shows date, status of pending court cases, number of cases closed by category, number of cases filed by category, case load summary, etc.~~

~~D. Retention:~~ ~~until annual report produced by the administrative office of the courts~~] **[RESERVED]**
[5-11-94, 1-10-97, 5-19-97; 1.17.218.102 NMAC - Rn, 1 NMAC 3.2.92.218.03.102, 1-6-02; Repealed, 7-3-04]
[Repealed section (records series name): *court clerk case load summary report, monthly*]

1.17.218.103 [~~DOCKET BOOK:~~

~~A. Program:~~ ~~general records~~

~~B. Maintenance:~~ ~~none~~

~~C. Description:~~ ~~book used to assign docket number to court cases. Shows docket number, date complaint filed, type of charges, defendant name, etc.~~

~~D. Retention:~~ ~~one year after close of fiscal year in which created~~] **[RESERVED]**
[5-11-94, 1-10-97, 5-19-97; 1.17.218.103 NMAC - Rn, 1 NMAC 3.2.92.218.03.103, 1-6-02; Repealed, 7-3-04]
[Repealed section (records series name):

docket book]

1.17.218.104 OATH OF OFFICE FILE:

A. Program: general records

B. Maintenance: none

C. Description: oaths of office administered by magistrate court judge to municipal judges, municipal officials, and school board members. Oaths show name of judge, name of clerk, court, date, oath and affirmation, signatures, seal, etc.

D. Retention: permanent. Transfer to the New Mexico state archives after five years.

[5-11-94, 1-10-97, 5-19-97; 1.17.218.104 NMAC - Rn, 1 NMAC 3.2.92.218.03.104, 1-6-02; A, 7-3-04]

1.17.218.105 [~~J U D G M E N T COPIES FILE:~~

~~**A. Program:** general records~~

~~**B. Maintenance:** none~~

~~**C. Description:** Copies of judgments used for case count. Original filed in case file.~~

~~**D. Retention:** until annual report for AOC released~~] **[RESERVED]**

[5-11-94, 1-10-97, 5-19-97; 1.17.218.105 NMAC - Rn, 1 NMAC 3.2.92.218.03.105, 1-6-02; Repealed, 7-3-04]

[Repealed section (records series name): *judgment copies file*]

1.17.218.106 JUROR DOCUMENT FILE:

A. Program: general records

B. Maintenance: chronological by date juror pool created

C. Description: [~~contains~~] record concerning jury composition. File may contain court orders, statistical reports, juror summons, juror questioners, excusals, postponements, juror list, correspondence, memoranda, etc.

D. Retention: six months after date created or until next jury is created whichever is longer

E. Confidentiality: Portions of this file may be confidential (e.g., juror address, juror telephone number, juror questionnaire).

[5-11-94, 1-10-97, 5-19-97; 1.17.218.106 NMAC - Rn, 1 NMAC 3.2.92.218.03.106, 1-6-02; A, 7-3-04]

1.17.218.107 MONTHLY TRANSACTION REPORT FILE:

A. Program: general records

B. Maintenance: [~~none~~] chronological by fiscal year then by month

C. Description: [~~file contains~~] copy of monthly report prepared by the administrative office of the courts and sent to magistrate court for signature and verification. File also contains copies of those financial documents submitted to the AOC for creating the monthly transaction report. Those documents include: cash bond record; schedule of partial payments; outstanding check schedule, bank statements, etc.

D. Retention: three years after close of fiscal year in which created

[6-5-76, 1-10-97, 5-19-97; 1.17.218.107 NMAC - Rn, 1 NMAC 3.2.92.218.03.107, 1-6-02; A, 7-3-04]

[Original report is returned to the AOC after verified and signed by the magistrate court.]

1.17.218.108 BOND FILES:

A. Program: general records

B. Maintenance: [~~none~~] alphabetical by defendant name

C. Description: Record concerning the cash or surety posted to procure the release of a defendant and to ensure his or her future appearance in court, compelling him or her to remain in the jurisdiction of the court. File [~~contains~~] may contain appearance property bond and power of attorney, order setting conditions of release bail bond, agreement to comply with all conditions of release, etc.

D. Retention:

(1) Charges filed: until filed in case file

(2) No charges filed: one year after date created

[6-5-76, 1-10-97, 5-19-97; 1.17.218.108 NMAC - Rn, 1 NMAC 3.2.92.218.03.108, 1-6-02; A, 7-3-04]

1.17.218.109 BOND BOOK:

A. Program: financial

B. Maintenance: chronological by date posted

C. Description: Record of cash or surety to be posted for release of a defendant on bail. Record may show cashier, person posting cash or surety, cash or surety amount, defendant name, date posted, amount posted, check number, bond number, docket number, arrest number, fines, court costs, amount and date of bond returned, etc.

D. Retention: three years after close of fiscal year in which last bond contained is disposed

[1.17.218.109 NMAC - N, 7-3-04]

1.17.218.110 COURT PERFORMANCE CERTIFICATION FILE:

A. Program: financial

B. Maintenance: chronological by date posted

C. Description: Financial control record concerning the certification of services performed in the court and submitted to the AOC for payment. Record may show type of service, date of performance, case number, court, certified performance, amount to be paid by the AOC.

D. Retention: three years after close of fiscal year in which last bond contained is disposed

[1.17.218.110 NMAC - N, 7-3-04]

[Court services include those of interpreter, expert witness, jury, guardian ad litem, etc.)

1.17.218.111 - 1.17.218.120 [RESERVED]

1.17.218.121 CRIMINAL CASE FILE:

A. Program: criminal matters

B. Maintenance: [~~chronological~~] numerical by case number

C. Description: [~~contains~~] record of criminal proceedings before the magistrate court. File may contain criminal complaint, arrest warrants, arraignment sheet, bonding documents, preliminary hearing papers, request for hearing, motions, disposition instruction sheet, citation, etc.

D. Retention: one year after case dismissed, entry of judgment or final order, provided audit report has been released, and provided all conditions of judgment have been met

E. Note bene

(1) If complaint filed, issuance of a search warrant requires the creation of case file and docket card. If no complaint filed, search warrant shall be destroyed one year after date warrant issued.

(2) When citations are filed, a docket number shall be issued and a case file created.

(3) DWI files resulting in conviction after July 1, 1985 shall not be destroyed until data has been transferred to an approved JISC system in accordance with JISC guidelines.

(4) *Criminal case file* shall not be destroyed until corresponding bonds are disposed.

[6-5-76, 1-10-97, 5-19-97; 1.17.218.121 NMAC - Rn, 1 NMAC 3.2.92.218.03.201, 1-6-02; A, 7-3-04]

1.17.218.122 [~~CRIMINAL TRANSCRIPTS, TAPES, COURT REPORTER NOTES~~] CRIMINAL PROCEEDINGS RECORDING:

A. Program: criminal matters

B. Maintenance: [~~none~~] numerical by docket number [tapes may be maintained chronological by court date]

C. Description: [~~none~~] verbatim record of court proceedings (e.g., tapes, court reporter notes, transcripts, etc.)

D. Retention:

(1) Appeal or bound over to district court: until transferred to district court

(2) No appeal or remanded from district court: six months after judgment date (SCRA 1986, 6-202B)

E. Note bene: Tapes may be destroyed when the transcript thereof has been accepted by the court.

[4-23-81, 1-10-97, 5-19-97; 1.17.218.122 NMAC - Rn, 1 NMAC 3.2.92.218.03.202, 1-6-02; A, 7-3-04]

1.17.218.123 C R I M I N A L EXHIBITS:

A. Program: criminal matters

B. Maintenance: [~~none~~] numerical by docket number

C. Description: [~~none~~] materials introduced as evidence in court case. Materials include documents (e.g., depositions, interrogatives, requests for admission, reports, etc.), personal possessions, weapons, etc.

D. Retention:

(1) Appeal or bound over to district court: until transferred to district court

(2) No appeal or remanded from district court: 30 days after judgment date

E. C o n f i d e n t i a l i t y : Individual exhibits may be confidential by protective court order.

F. Note bene: Unless otherwise ordered by the court, parties or their attorneys shall be given written notice by the clerk that the exhibits in the custody of the clerk will be disposed of 30 days from the date of notice unless retrieved by them. Clerks may release exhibits to the introducing parties or their attorneys as soon as the retention has been met, whether or not disposition notice has been issued. An exhibit remains the property of the party tendering the exhibit. Failure of a party to repossess an exhibit within sixty days from notice of the court terminates the legal interest of the party in that exhibit.

[5-11-94, 1-10-97, 5-19-97; 1.17.218.123 NMAC - Rn, 1 NMAC 3.2.92.218.03.203, 1-6-02; A, 7-3-04]

1.17.218.124 [~~CRIMINAL DOCKET CARD INDEX:~~

~~A. Program:~~ ~~criminal matters~~

~~B. Maintenance:~~ ~~none~~

~~C. Description:~~ ~~shows clerk, judge, court type, date, time, page, violation date, arrest number, bond amount, bond type, bond posted by, case number, defendant name, date of birth, social security number, arresting officer, arresting agency, attorney, waiver, trial type, citation, statute or ordinance, charge, plea, judgment, sentence, fine, court cost, lab fee, correctional fee, etc.~~

~~D. Retention:~~ ~~three years after case dismissed, entry of judgment, final order, but not prior to destruction of corresponding case file~~] **[RESERVED]**

[6-5-76, 1-10-97, 5-19-97; 1.17.218.124 NMAC - Rn, 1 NMAC 3.2.92.218.03.204, 1-6-02; Repealed, 7-3-04]

[DWI docket card indices created between July 1985 and June 1995 shall not be destroyed until docket information has been entered in the FACTS system.]

[Repealed section (records series name): *criminal docket card index*]

1.17.218.125 - 1.17.218.130 [RESERVED]

1.17.218.131 CIVIL CASE FILE:

A. Program: civil matters

B. M a i n t e n a n c e : [~~chronological~~] numerical by case number

C. D e s c r i p t i o n : [~~contains~~] record of civil proceedings before the magistrate court. File may contain complaint, request for hearing, answer, counter-claims, motions, pretrial orders, entry of appearance, settings, tape control sheets, orders, judgments, notice of appeal, remands, writs, garnishments, executions, satisfaction judgments, correspondence, memoranda, etc.

D. Retention: one year after case dismissed or until satisfaction of judgment, provided audit report has been released, but not more than 14 years after judgment date unless judgment is revived: then seven years after revival date.

[6-5-76, 1-10-97, 5-19-97; 1.17.218.131 NMAC - Rn, 1 NMAC 3.2.92.218.03.301, 1-6-02; A, 7-3-04]

1.17.218.132 [~~CIVIL TRANSCRIPTS, TAPES, COURT REPORTER NOTES~~] CIVIL PROCEEDINGS RECORDING:

A. Program: civil matters

B. Maintenance: [~~none~~] numerical by docket number [tapes may be maintained chronological by court date]

C. Description: [~~none~~] verbatim record of court proceedings (e.g., tapes, court reporter notes, transcripts, etc.)

D. Retention:

(1) Appeal: until transferred to district court

(2) No appeal or remanded from district court: 30 days after judgment date

E. Note bene: Tapes may be destroyed when the transcript thereof has been accepted by the court.

[4-23-81, 1-10-97, 5-19-97; 1.17.218.132 NMAC - Rn, 1 NMAC 3.2.92.218.03.302, 1-6-02; A, 7-3-04]

1.17.218.133 CIVIL EXHIBITS:

A. Program: civil matters

B. Maintenance: [~~none~~] numerical by docket number

C. Description: [~~none~~] materials introduced as evidence in court case. Materials include documents (e.g., depositions, interrogatives, requests for admission, reports, etc.), personal possessions, etc

D. Retention:

(1) Appeal: until transferred to district court

(2) No appeal or remanded from district court: 30 days after judgment date

[5-11-94, 1-10-97, 5-19-97; 1.17.218.133 NMAC - Rn, 1 NMAC 3.2.92.218.03.303, 1-6-02; A, 7-3-04]

1.17.218.134 [~~CIVIL DOCKET CARD INDEX:~~

~~A. Program:~~ ~~civil matters~~

~~B. Maintenance:~~ ~~none~~

~~C. Description:~~ ~~shows clerk, judge, court type, date, time, page plaintiff name, case number, prior to defendant name, attorney, waiver, trial type, judgement, sentence, court cost, etc.~~

~~D. Retention:~~ ~~three years after dismissal, satisfaction of judgment, but not destruction of corresponding case file~~] **[RESERVED]**

[6-5-76, 1-10-97, 5-19-97; 1.17.218.134 NMAC - Rn, 1 NMAC 3.2.92.218.03.304, 1-6-02; Repealed, 7-3-04]

[Repealed section (records series name): *civil docket card index*]

1.17.218.135 -1.17.218.140 [RESERVED]

1.17.218.141 C H I L D R E N ' S DETENTION HEARING FILE:

A. Program: children's detention matters

B. Maintenance: numerical by docket number

C. Description: record of children's detention proceedings before the magistrate court. Record of detention matters initiated by juvenile parole officers involving: assault, battery and escape from a juvenile detention facility; malicious mischief; violation of probation conditions; etc. File may contain complaints, petitions, orders, motions, notices, *entry of appearance*, social services reports, *subpoenas*, settings, tape control sheets, judgments, *notice of appeal*, *order for record proper*, disposition on appeal, correspondence,

memoranda, etc.

D. Retention: one year after case dismissed, entry of judgment or final order, provided audit report has been released, and provided all conditions of judgment have been met

E. Confidentiality: confidential per 32A-2-32, NMSA 1978. Traffic Code and Motor Vehicle Code violations are exempted from confidentiality requirements per 32-1-48C, NMSA 1978.

[1.17.218.141 NMAC - N, 7-3-04]

1.17.218.142 CHILDREN'S DETENTION PROCEEDINGS RECORDING:

A. Program: children's detention matters

B. Maintenance: numerical by docket number [tapes may be maintained chronological by court date]

C. Description: verbatim record of court proceedings (e.g., tapes, court reporter notes, transcripts, etc.)

D. Retention:

(1) Competent minor: four years after final judgment, or one year after age of majority, whichever is longer

(2) Incompetent minor: four years after declaration of competency but not less than one year after age of majority

(3) Record where original has been transmitted to district court: 60 days after date of transmittal [retention on copies of record retained at magistrate court]

E. Confidentiality: confidential per 32A-2-32, NMSA 1978. Traffic code and motor vehicle code violations are exempted from confidentiality requirements per 32-1-48C, NMSA 1978.

[1.17.218.142 NMAC - N, 7-3-04]

1.17.218.143 CHILDREN'S DETENTION HEARING EXHIBITS:

A. Program: children's detention matters

B. Maintenance: numerical by docket number

C. Description: materials introduced as evidence in court hearing. Materials include documents (e.g., depositions, interrogatives, requests for admission, reports, etc.), personal possessions, weapons, etc.

D. Retention:

(1) Competent minor: one year after final judgment, or one year after age of majority, whichever is longer

(2) Incompetent minor: one year after declaration of competency

E. Confidentiality: confidential per 32A-2-32, NMSA 1978. Traffic code and motor vehicle code violations are exempted from confidentiality requirements per 32-1-48C, NMSA 1978.

F. Note bene: Unless otherwise ordered by the court, parties or their attorneys shall be given written notice by the clerk that the exhibits in the custody of the clerk will be disposed of 60 days from the date of notice unless retrieved by them. Clerks may release exhibits to the introducing parties or their attorneys as soon as the retention has been met, whether or not disposition notice has been issued. An exhibit remains the property of the party tendering the exhibit. Failure of a party to repossess an exhibit within sixty days from notice of the court terminates the legal interest of the party in that exhibit.

[1.17.218.143 NMAC - N, 7-3-04]

HISTORY OF 1.17.218 NMAC:

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

SRC Rule 76-3, Records Retention and Disposal Schedule for Magistrate Court, 5-5-76.

SRC Rule No. 81-1, Records Retention and Disposition Schedule for Magistrate Court, 3-23-81.

SRC Rule No. 93-08, Records Retention and Disposition Schedule for New Mexico Magistrate Court, 4-11-94.

History of Repealed Material: [RESERVED]

NEW MEXICO COMMISSION OF PUBLIC RECORDS

This is an amendment to 1.24.1 NMAC, Section 7, effective June 30, 2004.

1.24.1.7 DEFINITIONS:

A. "Agency" means any agency, board, commission, department, institution or officer of the state government except the judicial and legislative branches (Subsection A of Section 14-4-2 NMSA 1978).

B. "Amendment" means a change or modification to the existing text of a rule. An amendment can be no less than a section. A repeal of less than a part is an amendment.

C. "Annotation" means referenced material that is not part of the rule, located in brackets at the end of a section.

D. "Chapter" means the required NMAC designation for the normal division of a title. Chapter names and numbers are assigned by the records center, based upon the subject matter covered by agencies' rule filings. The chapter identifies distinct governmental functions, or subject-matter areas, usually, but not always, under the jurisdiction of a single agency.

E. "Cited material" means the source document from which the rule text was derived. The source document need not be consulted in order to determine what the rule is.

F. "Compilation" means the composition of filed rules into the New Mexico administrative code.

G. "Duration" means the length of time a rule is intended to be in effect, either permanent or for a set period of time. It is placed in the required NMAC section entitled DURATION.

H. "Effective date" means the date the rule goes into effect. It is placed in the required NMAC section entitled EFFECTIVE DATE. A rule's effective date cannot be earlier than the date of publication in the New Mexico register.

I. "Emergency rule" means a rule filing whose immediate implementation is necessary for the public peace, health, safety or general welfare.

J. "Filing" means the process by which one paper copy of a part or amendment, the corresponding electronic copy and the NMAC transmittal form are delivered to the records center and, if accepted by the records center, are date stamped and accessioned. See also "rule filing".

K. "Filing date" means the date a rule filing is date stamped by the records center.

L. "History note" means the required annotation of changes or repeals to a part or a section noted at the end of a modified section. At a minimum, this note contains the [~~original filing's~~] effective date of the original filing and the dates and identification numbers of any subsequent amendment(s), promulgation(s) and any repeal.

M. "History of repealed material" means the listing of repealed pre-NMAC or NMAC material that pertains to the subject matter of the part. The listing contains the pre-NMAC rule number or NMAC number and the name and the effective date of repeal for each repealed rule or part. It is placed in the history of the part.

N. "History of the part" means the material located after the last section of the part comprising pre-NMAC history and history of repealed material.

O. "Incorporation by reference" see "referenced material incorporated or adopted by rule".

P. "Integrated part" means a compiled part that incorporates amendments to sections of that part.

Q. "Issuing agency" means the agency that originally promulgated the rule, or its successor agency. It is listed in the required NMAC section entitled

ISSUING AGENCY.

R. "Issuing authority" means the public official or employee of the issuing agency who is specifically authorized to approve the issuance of rules for that agency.

S. "Name" means the textual designation of a title, chapter, part or section.

T. "New part" means a part which did not previously exist in the New Mexico administrative code and where no pre-NMAC rules exist covering the same subject matter, or a complete replacement of an entire part and its amendments.

U. "NMAC" means the New Mexico administrative code, the organizing structure for rules filed by New Mexico state agencies. The NMAC is also the body of filed rules and the published versions thereof. The hierarchy of the NMAC is structured by title, chapter, part and section.

V. "NMAC table of contents" means the master list of approved NMAC titles maintained by the records center. It may also include chapter and part designations.

W. "Notice of rulemaking" means the advertisement published in the New Mexico register to provide public notice of an agency's intention to promulgate a rule(s) along with the date and time of hearings for the purpose of collecting public comment on the proposed rule(s).

X. "Number" means the numerical designations assigned to titles, chapters, parts and sections that combine to form a unique numerical designation for a rule. Numbers need not be sequentially assigned and intermediate ranges may be reserved.

Y. "Objective" means the purpose of the rule or the reason for its necessity. It is stated in the required NMAC section entitled OBJECTIVE.

Z. "Original filing" means the first filing of new rule material.

AA. "Part" means the required NMAC designation for the normal division of a chapter. A part consists of a unified body of rule material applying to a specific function or devoted to a specific subject matter. Structurally, a part is the equivalent of a rule. [~~Part numbers and names are assigned by the agency and approved by the records center.~~]

BB. "Paragraph" means the normal division of a subsection and the sixth level of the NMAC hierarchy. Paragraphs are identified by a number within parentheses.

CC. "Pre-NMAC history" means the regulatory filing history (list) of filed rules, prior to converting to NMAC style and format, that provided the source material for the specific NMAC part. It contains the rule number, the rule name and the filing date for each listed rule.

DD. "Promulgation" means the public declaration of the adoption of an official and final rule.

EE. "Publication in the New Mexico register" means the process of publishing in the New Mexico register in accordance with 1.24.15 NMAC. The publication date is the date of the issue of the New Mexico register in which a rule appears.

FF. "Recompile" means the action of renumbering, reformatting and restructuring an existing rule without changing the text so that it complies with the current NMAC style and formatting requirements. Rules are recompiled for the convenience of using the NMAC website. The original filing remains the official version of the rule.

[~~FF.~~] GG. "Records center" means the commission of public records, state records center and archives, the agency responsible for administering the State Rules Act, Section 14-4-1 et seq. NMSA 1978.

[~~GG.~~] HH. "Referenced material incorporated or adopted by rule" means a source document that must be consulted in order to determine what the rule is, where such incorporated or adopted material is not stated in the rule.

[~~HH.~~] II. "Reformat" means the application of adopted style and format requirements to current rules to conform to the NMAC structure promulgated by the records center.

[~~II.~~] JJ. "Renumbering" means the assignment of a new number to an existing chapter, part or section.

[~~JJ.~~] KK. "Repealer" means a rule filing which revokes or annuls an entire part.

[~~KK.~~] LL. "Re-promulgation" means the filing of pre-existing rule material with the express intent that it continue in effect, or resume being in effect. This was done specifically pursuant to Subsection D of 14-4-7 NMSA 1978.

MM. "Reserved" means portions of the New Mexico administrative code (NMAC) with the word RESERVED in square brackets. Chapters, parts and sections may be reserved to hold space between lower numbered and higher numbered portions of the hierarchy, or may be reserved by agencies with the intent to write rule text in that area.

[~~LL.~~]NN. "Restructuring" means the reformatting and reorganizing of the hierarchy of the NMAC by assigning new designations to existing rule material without altering the content of that material.

[~~MM.~~] OO. "Rule" means any rule, regulation, order, standard or statement of policy, including amendments thereto or repeals thereof, issued or promulgated by an agency of state government and purporting to affect one or more agencies besides the agency issuing the rule or to affect persons not members or employees of the issuing agency, and as further defined in subsection C of Subsection 14-4-2 NMSA 1978 and Attorney General Opinion No. 93-1.

[~~NN.~~] PP. "Rule filing" means the body of rule material organized for filing in accordance with Section 14-4-3 NMSA 1978 and 1.24.10 NMAC.

[~~OO.~~] QQ. "Scope" means the extent of a rule's coverage. It identifies to whom the rule applies and whom it affects - for example, to the general public, for-profit corporations, public utilities, all state agencies, etc. It includes exclusions from coverage, and cross-reference to other parts of the NMAC which deal with the same or similar subject matter. It also indicates whether the rule is exhaustive of the subject area and whether other rules may apply. It is stated in the required NMAC section entitled SCOPE.

[~~PP.~~] RR. "Section" means the required NMAC designation for the normal subdivision of a part. It has both a name and number, is the smallest filable unit of a rule filing and of the NMAC and is the fourth level of the NMAC hierarchy.

[~~QQ.~~] SS. "Statutory authority" means the statute or constitutional provision which authorizes the promulgation of rules concerning the topic of the part. In the absence of express legislative authority, statutory authority cites to the general legislative authority of the agency over the topic of the rule. It is stated in the required NMAC section entitled STATUTORY AUTHORITY.

[~~RR.~~] TT. "Sub-paragraph" means the normal subdivision of a paragraph that is always the seventh level of the NMAC hierarchy. Sub-paragraphs are identified by a lower case letter within parentheses.

[~~SS.~~] UU. "Subsection" means the normal subdivision of a section and is always the fifth level of the NMAC hierarchy. A subsection is identified by a capital letter.

[~~TT.~~] VV. "Synopsis" means a condensed version or outline of a rule.

[~~UU.~~] WW. "Title" means the required NMAC designation for the major divisions of the NMAC. Each title brings together broadly related governmental functions and is the first level of the NMAC hierarchy. Titles shall be assigned by the records center.

[~~VV.~~] XX. "Title case" means the style where the first letter of each

significant word is capitalized.

[~~WW. "Translation table" means the table showing the changes made, or to be made during compilation. The table includes the old citation and the new citation.~~]

[~~XX.~~] YY. "URL" means the internet address of a web site.

[~~YY.~~] ZZ. "U.S. law" means the United States code, the code of federal regulations, the federal register, New Mexico statutes, published portions of the NMAC and any material referenced therein.

[1.24.1.7 NMAC - Rp 1 NMAC 3.3.10.7 & 1 NMAC 3.3.15.7 & 1 NMAC 3.3.20.7, 2/29/2000; A, 6/30/2004]

[The most recent amendment includes definitions not previously promulgated.]

NEW MEXICO COMMISSION OF PUBLIC RECORDS

This is an amendment to 1.24.10 NMAC, Sections 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 22 and 25, effective June 30, 2004.

1.24.10.8 NMAC STRUCTURE AND IDENTIFICATION:

A. The NMAC, a hierarchical structure, is divided into titles, chapters and parts, on the basis of subject matter. A title broadly organizes related governmental rule material in the first level of the hierarchy. The title is divided into chapters that identify distinct governmental functions. The chapter is divided into parts. The part relates to specific subject matter. It is at this level that rules are organized. The part is subdivided into sections. The section may be further subdivided into subsections, paragraphs and sub-paragraphs.

B. Each division of the NMAC through the section level shall have a name and number.

(1) The names and numbers of NMAC titles are listed in 1.24.10.26 NMAC, TABLE OF CONTENTS. Chapter names and numbers shall be assigned and maintained by the records center.

(2) The individual number of a title, chapter, part or section shall be expressed as a whole number. Titles shall be limited to two arabic digits; chapters shall be limited to three arabic digits; and parts and sections shall be limited to four arabic digits.

C. Subsections shall be indicated by at least one, but not more than three, upper-case alphabetic characters. Paragraphs are indicated by at least one, but not more than three, arabic digits within parentheses. Sub-paragraphs shall be indicated by at least one, but not more than three, lower-case alphabetic characters within parentheses.

D. The part name and number shall be assigned by the filing agency and subject to approval by the records center.

(1) The part names shall be descriptive and not exceed 120 characters. Agencies shall use names that provide adequate notice of the nature and content of the part.

(2) The individual part number shall not exceed four arabic digits and shall not include dashes or alphabetic characters.

(3) "Part 1" of each chapter shall be used or reserved for the general provisions that apply to all the parts in that chapter.

E. At the beginning of each part, an agency shall identify the part by title number and name, chapter number and name, and part number and name.

F. The first seven sections of each part shall state:

(1) Section 1 - name of the issuing agency in a section entitled "ISSUING AGENCY";

(2) Section 2 - the scope of the part in a section entitled "SCOPE";

(3) Section 3 - the statutory authority under which a part is issued, in a section entitled "STATUTORY AUTHORITY";

(4) Section 4 - the intended duration of the part in a section entitled "DURATION";

(5) Section 5 - the effective date of the part in a section entitled "EFFECTIVE DATE";

(6) Section 6 - the objective of the part in a section entitled "OBJECTIVE";

(7) Section 7 - the definitions that apply just to the part in a section entitled "DEFINITIONS." If there are no definitions for the part, Section 7 shall be reserved i.e [RESERVED]. An annotation to general provisions may be included.

G. Section 8, and all subsequent sections, shall encompass the body of rule material specific to the part.

H. A section has both a name and number assigned by the promulgating agency. Each section shall be identified at the beginning by the full NMAC number (title number, followed by a period, chapter number, followed by a period, part number, followed by a period and the section number) followed by the name of the section. Example: Section 12 of this part is 1.24.10.12 STYLE

I. A section may be divided into subsections. Subsections may be used to further group similar paragraphs.

J. A paragraph is a unit of grammatical, tabular or other discrete, organized information that may be, although not advisably, divided into further units.

[1.24.10.8 NMAC - Rp 1 NMAC 3.3.10.15, 2/29/2000; A, 6/30/2004]

1.24.10.9 NMAC CITATION:

A. The [~~recommended~~] format for full citation of material contained in the NMAC shall be the name of the part, followed by a comma, a space, the name of the issuing agency, followed by a comma, a space, the title number, followed a period, the chapter number, followed by a period, the part number, followed by a period, the section number, a space and the initials "NMAC." The citation shall be followed by the effective date in parentheses. Example: Disclosure of Taxpayer Information, New Mexico Taxation and Revenue Department, 3.1.3.8 NMAC (10/31/1996)

B. A modified full citation where the name of the issuing agency is omitted from the citation may be used. Example: Disclosure of Taxpayer Information, 3.1.3.8 NMAC (10/31/1996)

C. The [~~recommended~~] short-form citation of the NMAC is the title, chapter, part and section number separated by periods and followed by "NMAC". Example: 3.1.3.8 NMAC

D. Where a provision has been amended, the effective date shall be the effective date of the version that is being cited.

E. Where reference is to the whole part, the reference date shall be the original effective date together with the date of last amendment, i.e., (7/1/94 as amended through 1/1/2000.)

F. Where citation below the level of a section is desired, designations below the section shall precede the citation. Example: Subsection A of 3.1.3.8 NMAC.

[1.24.10.9 NMAC - Rp 1 NMAC 3.3.10.8, 2/29/2000; A, 6/30/2004]

1.24.10.10 ISSUING AUTHORITY:

A. The issuing authority is responsible for ensuring compliance with the requirements set forth in this part.

B. Where delegation is authorized, the agency may, by rule or formal appointment, specify an issuing authority other than that named in statute. The agency shall forward, in writing, the title, name and signature of the designee to the [~~records center~~] state records administrator. The agency shall notify, in writing, the [~~records center~~] state records administrator of any change in the designation. Designation shall only be made by the issu-

ing authority. Formally appointed designees are not allowed to appoint other designees.

C. The records center shall not accept a rule filing signed by other than the issuing authority, or a formally appointed designee.

[1.24.10.10 NMAC - Rp 1 NMAC 3.3.10.9, 2/29/2000; A, 6/30/2004]

1.24.10.11 WHAT CONSTITUTES A RULE:

A. Agency directives that affect persons outside the agency or have significant indirect affect upon such persons are rules.

B. Manuals of procedure may contain material that affects other state agencies, the public or agency clients. Such material shall be filed as a rule. If it cannot be separated from other material, the entire manual shall be filed. Agencies are encouraged to separate rule material even if it is later included in a manual of procedure.

C. Procedures for public hearings and open meetings shall be filed as a rule.

D. Contracts, requests for proposals (RFPs) or requests for information (RFIs), including form contracts, are not rules; however, agencies may issue rules that require contractual terms.

E. Materials specifically exempted by statute from the State Rules Act are not rules.

F. Computations of annual assessments based on rule or statute are not rules - i.e., tax tables.

G. Minutes of meetings are not rules.

[1.24.10.11 NMAC - N, 2/29/2000; A, 6/30/2004]

1.24.10.12 STYLE:

A. Style shall be guided by relevant portions of the current edition of the legislative drafting manual of the New Mexico legislature published by the New Mexico legislative council service. The following provisions are specifically adopted.

(1) Chapter 4, Bill Drafting, the portion dealing with brackets, line-through and underscoring shall apply to proposed amendments and amendments for publication in the New Mexico register. This style shall not be applied to the integrated part.

(2) Chapter 7, Legislative Style and Language Provisions, except for the portion dealing with numbers, formulas and charts.

(3) Figures and symbols may represent amounts of money. It is not necessary to spell out the number.

B. Special symbols shall be avoided and the common abbreviation or full spelling used instead. For example, deg. for degree and lbs. for pounds.

C. No rule filing shall be typed in all capital letters.

D. Indentions shall be standardized as follows.

(1) Section numbers shall be flush with the part's one-inch margin.

(2) One tab shall be used to indent the first line of a subsection. Tab once after the subsection designation before beginning the text.

(3) Paragraphs shall be indented 20 spaces. Do not use tabs.

(4) [~~Subdivisions below the paragraph~~] Subparagraphs shall be indented 30 spaces. Do not use tabs.

(5) After the numeric or alphabetic designation for a paragraph or subparagraph, indent five spaces before the beginning of the text.

(6) [~~Hanging~~] Automatic indents are not permitted.

E. Sections shall be clearly separated.

F. The name of the issuing agency in Section 1 and in full citation shall be typed in title case.

G. The [~~heading of the~~] first page of a new part or integrated part shall [~~contain~~] begin with the title, chapter and part numbers and names. The [~~header and related~~] information shall be flush with the document's one-inch margin and typed in [~~all~~] bold capital letters. Example:

TITLE 3 TAXATION
CHAPTER 1 TAX ADMINISTRTION
PART 3 DISCLOSURE OF TAXPAYER INFORMATION

H. Use of tables [~~shall be limited~~] is permissible but shall be used sparingly because tables may cause difficulties in the rule filing process and may increase publication costs. The agency shall be guided by the following [~~considerations in determining whether to use~~] when using tables.

[~~(1) The text in tables will not be searchable.~~

~~(2) Tables will require extra keystrokes to access.~~

~~(3) Tables increase publication costs.~~]

(1) Tables shall be in portrait orientation.

(2) Text in tables shall be Times New Roman, 10-point font.

I. No rule filing shall contain footnotes.

[1.24.10.12 NMAC - N, 2/29/2000; A, 6/30/2004]

1.24.10.13 E L E C T R O N I C STANDARDS:

A. Electronic storage media for rule filings shall be one of the following:

(1) diskette shall be 3.5 inches IBM format, high density; [~~or~~]

(2) CD-ROM, IBM format; or,

(3) Zip disk, IBM format.

B. For rule filings, the electronic format shall be *MS Windows* version of *MS Word* software using Times New Roman, 10-point font, normal style.

C. Special coding, such as hanging indents, automatic tabbing, automatic numbering, body text style, nonbreaking hyphens, automatic tracking, etc. shall not be used.

D. [~~Tables shall be included in the electronic version of the documents as GIF or PDF files.~~

~~E.~~] Use of images shall be limited. If necessary, they shall be included in the electronic version of the document as GIF or PDF files.

[1.24.10.13 NMAC - Rp 1 NMAC 3.3.10.13, 2/29/2000; A, 6/30/2004]

1.24.10.14 PAPER VERSION STANDARDS:

A. Paper:

(1) Output shall be produced from, and not vary from, the electronic version of the rule filing.

(2) Size shall be 8.5 x 11 inches.

(3) Weight shall be a minimum of 20-lb. bond or copier paper.

(4) Color shall be white.

B. Ink: Color shall be black and uniform throughout.

C. Binding: Rule filings shall be unbound and consist of individual sheets.

D. Page Layout:

(1) A rule filing shall be single-spaced with [~~increased or~~] double spacing between sections.

(2) The original paper version of a rule filing shall be single-sided.

(3) Margins shall be a minimum of one inch on all four sides, excluding the footer.

(4) Tabs shall be set at 0.5 inches.

(5) The word processing document shall have a footer for page identification which shall appear at the midpoint within the one-inch margin on the foot of every page. The footer shall contain the NMAC number down through the part number in the bottom left corner of the footer. The page number shall be located at the bottom right corner of the footer.

[1.24.10.14 NMAC - Rp 1 NMAC 3.3.10.13, 2/29/2000; A, 6/30/2004]

1.24.10.15 NMAC TRANSMITTAL FORM:

A. Each rule filing delivered to the records center shall be accompanied by a completed NMAC transmittal

form in both hard copy and electronic format.

B. The records center shall provide agencies with blank NMAC transmittal forms in [~~both hard copy and~~] electronic format.

C. The filing agency shall complete the NMAC transmittal form prior to filing.

D. The NMAC transmittal form shall not be handwritten and shall be suitable for reproduction.

E. The [~~NMAC name and number~~] following shall appear on the NMAC transmittal form[~~.~~] :

[~~F.~~ ~~The NMAC transmittal form shall state the type of filing - i.e., original filing, amendment, repeal or emergency filing.~~

~~G.~~ ~~If a rule filing affects a pre-NMAC rule, the name, number and filing date of the pre-NMAC rule shall also be noted on the NMAC transmittal form.~~

~~H.~~ ~~The NMAC transmittal form shall state the date(s) of any public hearing(s) on the proposed rule or amendment.~~]

(1) issuing agency name;

(2) three digit DFA account code for the agency (if applicable);

(3) issuing agency mailing address;

(4) contact person's name, phone number, fax number and e-mail address;

(5) type of filing - i.e., new, amendment, renumber, repeal or emergency filing;

(6) total number or pages;

(7) date(s) of any public hearing(s) on the proposed rule or amendment;

(8) effective date of the rule filing (cannot precede publication in the New Mexico register unless it is an emergency rule);

(9) NMAC name and number;

(10) description of amendment;

(11) most recent filing date of the part (if applicable);

(12) declaration of incorporated material;

(13) if reference materials are attached and are protected by copyright:

(a) indication if copyright permission was obtained;

(b) the proof of permission; or

(c) material is within the definition of public domain;

(14) legal citation(s) that grants the issuing agency the authority to promulgate rules on the subject area; and

(15) legal citation(s) that specifies who can authorize the rule in the agency.

[~~I.~~] F. Each rule filing shall bear the original signature of the issuing authority or authorized designee in black ink on the paper copy of the NMAC transmittal form. If authority is delegated, the box shall be checked.

[1.24.10.15 NMAC - Rp 1 NMAC 3.3.10.11, 2/29/2000; A, 6/30/2004]

1.24.10.16 FILING A RULE:

A. At the time of filing the filing agency shall present:

(1) one paper and one electronic version of the completed NMAC transmittal form;

(2) one paper and one electronic version of the text of the rule or amendment; [~~and~~]

(3) one electronic version of the integrated part (if filing an amendment);

(4) one electronic version of the billing information sheet; and

(5) one copy of the purchase document.

B. Other material to be published in the New Mexico register in conjunction with promulgation of the rule or amendment shall be delivered to the records center at the time of filing. Examples include synopses, short-form publication, conversion tables and summaries of public comment.

C. At the time of filing, an agency may submit to the records center an additional paper copy, for annotation on the first page of the rule with the date and hour of filing, to be returned to the agency (Section 14-4-3 NMSA 1978).

D. If a short-form publication or synopsis is made in accordance with the requirements of 1.24.15 NMAC, the full text of the rule shall be submitted as part of the rule filing. The full text shall be published in the NMAC at no additional cost to the agency.

E. No rule shall be valid and enforceable until it is filed with the records center and published in the New Mexico register as provided by the State Rules Act. If properly submitted and not published as a result of error, the rule shall be deemed to have been published three weeks after filing with the records center (Sections 14-4-3 and 14-4-5 NMSA 1978).

[1.24.10.16 NMAC - Rp 1 NMAC 3.3.10.10, 2/29/2000; A, 6/30/2004]

1.24.10.17 REJECTED RULE FILINGS:

A. The records center shall refuse to file written material if it is not a rule as defined in 1.24.1.7 NMAC or if the materials submitted for rule filing do not conform to the style and format requirements detailed in 1.24.10 NMAC.

(1) Materials that are not rules may be filed as a publications.

(2) Rule filings that do not conform to style and format requirements shall be returned to the filing agency and shall not be [~~submitted for publication~~] filed or published in the New Mexico register.

B. The records center shall identify material previously filed as a rule but not conforming to the definition of a rule. The material shall be removed from the rules collection and rule history database with thirty days written notice to the affected agency.

C. If an affected agency finds it previously filed material as a rule that does not conform to the definition of a rule, that agency shall notify the records center in writing. If the record center agrees the material does not conform to the definition of a rule, the material shall be removed from the rules collection and the rule history database within thirty days of receiving the notice.

[1.24.10.17 NMAC - N, 2/29/2000; A, 6/30/2004]

1.24.10.18 AMENDMENTS TO AND REPEALS OF EXISTING RULES:

A. Amendments to the part shall be prepared by the agency in such a manner as to provide for full- section addition, substitution or deletion. Parts shall only be amended by replacement, deletion or addition of whole sections. Deleting, replacing or adding words and sentences to a section shall be accomplished by replacement of the whole section.

(1) If a section contains entirely new material, unrelated to the material formerly contained in the section with the same NMAC number, then the former section shall be repealed. The repeal shall be identified within the history note at the end of the [~~part~~] section with the appropriate notation (see 1.24.10.20 NMAC).

(2) An addition of a new section is an amendment to the part.

(3) If an entire part is being amended rather than repealed, the history notes shall reflect changes only in those sections in which there have been changes, including sections that are only renumbered.

(4) The first sentence on the first page of the text of an amendment shall state, "This is an amendment to (insert appropriate title number, chapter number, part number) NMAC, Section (insert the section number of the amended sections), effective (insert appropriate effective date)."

(5) For clarity, agencies may precede the text of an amendment with an explanatory paragraph to be published in the New Mexico register but which shall not be part of the rule.

B. Repeals shall be done by the issuing agency at the part level by identifying an expiration in the duration section of the part or by issuing a repealer. If less than a full part is being repealed, the

rule filing shall be treated as an amendment. If other parts are affected by the repeal, they shall be amended as appropriate.

(1) If a part has been entirely rewritten and restructured so that a detailed section by section comparison is not possible, the agency [~~could~~] may repeal the existing part and issue a new part with either the same or new part number. Where a new part number is used, an agency may record a reference to the pre-existing part in the historical note of the new part.

(2) The history note shall reflect the original NMAC effective date and number. When a part has been entirely repealed its history shall be reflected in the history of the part, which shall remain in the NMAC.

(3) Once a part number has been used in the NMAC, the history of the part shall continue to contain all NMAC history for that part, regardless of repealers.

~~[(4) If an entire part is being amended rather than repealed, the history notes shall reflect changes only in those sections in which there have been changes, including sections that are only renumbered.~~]

C. Superseding rule filings are not permitted. This activity shall be handled through amendment of the part or by repeal and replacement of the part.

~~[D. The first sentence on the first page of the text of an amendment shall state, "This is an amendment to [insert appropriate title number, chapter number, part number, section number] of the NMAC."~~

~~E. For clarity, agencies may precede the text of an amendment with an explanatory paragraph to be published in the New Mexico register but which shall not be part of the rule.~~]

[1.24.10.18 NMAC - Rp 1 NMAC 3.3.10.12, 2/29/2000; A, 6/30/2004]

1.24.10.20 HISTORY NOTE: History notes facilitate the use of the NMAC [~~in both paper and electronic format and permit tracing~~] and track the historical development of a rule provision.

A. There shall be a history note appended at the end of each section.

B. The history note shall contain the original effective date of sections filed after the implementation of NMAC. It shall also detail all subsequent amendments and number changes by section. Standard notations identified in this section shall be used to minimally identify the types of modifications made to sections.

(1) History shall appear in chronological sequence in brackets at the end of each section. A semicolon shall separate each significant change noted in the sequence of a section's history. Significant changes are: an amendment; a section number or name change; and an insertion of new rule material at a section number where previously repealed material had been located. Minimum dates required for each change are:

(a) effective date of new material;

(b) effective date of amended sections;

(c) effective date of repealed material; and

(d) effective date of the change to section numbers and names.

(2) If the section has been amended, note the new effective date and the nature of changes if possible. If the section has been renumbered, list the former number and the effective date of change.

(3) Agencies shall provide information, in addition to dates, in the history using the following system: Identify the short form of the affected part or section followed by a space, a dash, a space and then the letter or combination of letters identifying the type of change. The last date in a series indicates the date of the last change to the section. Use:

(a) "A" for amendment, followed by a comma, a space and the effective date of amendment;

(b) "Re-pr" for re-promulgated, followed by a comma, a space and the effective date of re-promulgation;

(c) "Rp" for replaced, followed by a comma, followed by the short form citation of the rule replaced, followed by a comma, a space and the effective date of replacement;

(d) "Rn" for renumbered, followed by a comma, the former number, a space and the effective date of renumbering; and

(e) "N" for new, followed by a comma, a space and the effective date of the new material;

(f) "Repealed" for a section that is deleted and not replaced, followed by a comma, a space and the effective date of the deletion; and

(g) "E" for an emergency filing, in combination with the appropriate action code and a slash (/).

C. The history note is not part of the rule.

[1.24.10.20 NMAC - Rp 1 NMAC 3.3.10.15.11.1 through 1 NMAC 3.3.10.15.11.3, 2/29/2000; A, 6/30/2004]

1.24.10.22 MATERIAL REFERENCED IN RULES:

A. The source of material, which is fully included in the text of the rule, may be given as a citation. Where there is no intent to include in the rule additional material by incorporation from the cited reference, the source material need not be attached.

B. Referenced material (including standards, codes and manuals) incorporated or adopted by rule must be filed as part of that rule which may be accomplished by attachment.

(1) Referenced material that has been formally published does not need to meet style and format requirements of 1.24.10 NMAC. A copy of this formally published material must be filed.

(2) Other attachments must meet all style, format and filing requirements, including provision of an electronic copy, unless an exception has been granted pursuant to 1.24.10.24 NMAC.

(3) [~~References to U.S. law require neither incorporation nor submittal of a copy.~~] References to U.S. law shall be deemed to be references to the current version of such law, including subsequent amendments, unless otherwise expressly stated in the rule. References to U.S. law do not require submittal or a copy. In lieu of submitting a paper copy of these references, the issuing authority shall on the NMAC transmittal form list the references and internet site. This information shall be verified by the records center at the appropriate internet site to ensure access is available to users of the NMAC. If an internet site is not available or cannot be located, one paper copy of the attachment shall be filed with the rule for historical reference.

(4) [~~Other referenced~~] Referenced material, other than U.S. law (including material referenced in New Mexico statutes or the NMAC), shall be the version filed with or referenced by the rule and shall not include any subsequent amendments or changes to the referenced material, unless otherwise expressly stated in the rule.

C. Referenced material that is not incorporated in the rule may be referenced in either the text or in an annotation. Annotations are not part of the rule.

[1.24.10.22 NMAC - Rp 1 NMAC 3.3.10.17.1 & 1 NMAC 3.3.10.17.2, 2/29/2000; A, 6/30/2004]

1.24.10.25 PROCEDURE FOR [~~OPTIONAL PRE-APPROVAL~~] APPROVAL OF NEW CHAPTERS AND PARTS:

A. If a chapter on a specific subject does not exist in the NMAC hierarchy, an agency may send a written request to the state records administrator for the creation of a new chapter. If the state records administrator approves the request, a new chapter will be created in the NMAC.

B. In order to avoid any delay in filing a rule, agencies [~~may~~] shall submit, in writing, proposed part names and numbers to the administrative law division of the records center. The administrative law division of the records center shall

approve or reject proposed part names and numbers within two weeks or shall notify the agency of further delay in approval. When the administrative law division of the records center rejects part names and numbers, it shall[~~, in the alternative, propose revised~~] propose alternative names and numbers for submitted parts and state the reason why the proposed names and numbers were unsatisfactory.
[1.24.10.25 NMAC - Rp 1 NMAC 3.3.10.20, 2/29/2000; A, 6/30/2004]

NEW MEXICO COMMISSION OF PUBLIC RECORDS

This is an amendment to 1.13.30 NMAC, Sections 1, 3, 5, 6, 7, and 9, effective June 30, 2004. This action also renumbers and reformats 1 NMAC 3.2.50.1 to 1.13.30 NMAC in conformance with current NMAC requirements.

TITLE 1 GENERAL GOVERNMENT ADMINISTRATION
CHAPTER 13 PUBLIC RECORDS
PART 30 DESTRUCTION OF PUBLIC RECORDS

1.13.30.1 ISSUING AGENCY: Commission of Public Records - State Records Center and Archives
[12-1-94; Rn, 1 NMAC 3.55, 5-15-97; 1.13.30.1 NMAC - Rn, 1 NMAC 3.2.50.1.1 & A, 6/30/2004]

1.13.30.2 SCOPE: all state agencies.
[12-1-94; Rn, 1 NMAC 3.55, 5-15-97; 1.13.30.2 NMAC - Rn, 1 NMAC 3.2.50.1.2, 6/30/2004]

1.13.30.3 S T A T U T O R Y AUTHORITY:

[~~A. Section 14-3-4(C) (D) NMSA 1978. Duties and powers of commission. It shall be the duty of the commission to: decide, by majority vote, any disagreements between the administrator and any state officer regarding the disposition of records within the custody of said officer, such decisions to have the effect of law; and consider the recommendations of the administrator for the destruction of specifically reported records, and by unanimous vote either order or forbid such destruction. (Emphasis added.)~~

~~B. Section 14-3-6 NMSA 1978. Administrator; duties. The administrator shall establish a records management program for the application of efficient and economical management methods to the creation, utilization, maintenance, retention, preservation and disposal of official records. The administrator shall establish records disposal schedules [records retention and disposition schedules] for the orderly retirement of records and adopt regulations necessary for the carrying out of the Public Records Act.~~

~~C. Section 14-3-9 (C) NMSA 1978. Disposition of public records. Public records in the custody of the administrator may be transferred or destroyed only upon order of the commission. (Emphasis added.)~~

~~D. Section 14-3-10 NMSA 1978. Disagreement as to value of records. In the event the attorney general and the administrator determine that any records in the custody of a public officer including the administrator are of no legal, administrative or historical value, but the public officer having custody of the records or from whose office the records originated fails to agree with such determination or refuses to dispose of the records, the attorney general and the administrator may request the state commission of public records to make its determination as to whether the records should be disposed of in the interests of conservation of space, economy or safety.~~

~~E. Section 14-3-11 NMSA 1978. Destruction of records. If it is determined by the administrator, attorney general and agency head that destruction of public records will be recommended, the administrator shall have prepared a list of records, together with a brief description of their nature, and shall place upon the agenda of the next meeting of the commission the matter of destruction of records. The records may be stored in the center awaiting decision of the commission. The commission's decision with reference to destruction of the records shall be entered on its minutes, together with the date of its order to destroy the records and a general description of the records which it orders to be destroyed. A copy of the commissions order shall be filed with the librarian of the supreme court library (now the state records center and archives, state rules division). No public records shall be destroyed if the law prohibits their destruction. (Emphasis added.)~~

~~F. Section 30-26-1 (E) NMSA 1978. Tampering with public records consists of: knowingly destroying, concealing, mutilating or removing without lawful authorization any public record or public document belonging to or received or kept by any public authority for information, records or pursuant to law. Whoever commits tampering with public records is guilty of a fourth degree felony.~~]

Section 14-3-6 of the Public Records Act (Chapter 14, Article 3, NMSA 1978) gives the state records administrator the authority to establish records and information management programs for the application of efficient and economical management methods for the creation, utilization, maintenance, retention, preservation and disposal of public records.
[12-1-94; Rn, 1 NMAC 3.55, 5-15-97; 1.13.30.3 NMAC - Rn, 1 NMAC 3.2.50.1.3 & A, 6/30/2004]

1.13.30.4 DURATION: permanent
[12-1-94; Rn, 1 NMAC 3.55, 5-15-97; 1.13.30.4 NMAC - Rn, 1 NMAC 3.2.50.1.4, 6/30/2004]

1.13.30.5 EFFECTIVE DATE: December 1, 1994 unless a later date is cited at the end of a section[~~, or paragraph~~.].
[12-1-94; Rn, 1 NMAC 3.55, 5-15-97; 1.13.30.5 NMAC - Rn, 1 NMAC 3.2.50.1.5 & A, 6/30/2004]

1.13.30.6 OBJECTIVE: [~~To provide for the efficient and systematic destruction of public records.~~]To establish methods for the orderly, efficient, and systematic destruction of public records.necessary for carrying out the Public Records Act per Section 14-3-6 NMSA 1978.
[12-1-94; Rn, 1 NMAC 3.55, 1.13.30.6 NMAC - Rn, 1 NMAC 3.2.50.1.6 & A, 6/30/2004]

1.13.30.7 DEFINITIONS:

[~~**A. Records:** Information preserved by any technique in any medium now known, or later developed, that can be recognized by ordinary human sensory capabilities either directly or with the aid of technology, Subsection A of 1.13.70.8 NMAC.~~

~~**B. Public records:** All books, papers, maps, photographs or other documentary materials, regardless of physical form or characteristics, made or received by any agency in pursuance of law or in connection with the transaction of public business and preserved, or appropriate for preservation, by the agency or its legitimate successor as evidence of the organization, functions, policies, decisions, procedures, operations or other activities of the government, or because of the informational and historical value of data contained therein. (Subsection C of Section 14-3-2 NMSA 1978). Public records are records either related to or received in pursuance of statutory requirements or in connection with the transaction of public business that belong to the office concerned. Value is the key ingredient of a public record. It is determined by:~~

~~**(1)** legal value to the state of New Mexico: to meet federal requirements; document property and water rights, etc.; generally to protect or enforce the rights of the~~

~~state and its citizens;~~

~~(2) administrative value: provides a chronology of actions, provides legitimacy of the operation; functions, policies, decisions, procedures, or other activities of the government;~~

~~(3) historical value: for example, New Mexico's records of the Spanish colonial government, the Mexican republic, early U.S. territorial government, etc. Also, an agency's primary mission records, which are files concerning the establishment of an agency, its development and policies, its progress, operation summaries, plans for future development, etc.; and~~

~~(4) financial value: accounting for whom, why, where and when money was budgeted, received or expended.~~

~~C. Non-records:~~

~~(1) Library or museum material of the state library, state institutions and state museums, extra copies of documents reserved only for convenience of reference and stocks of publications and processed documents are non-records (Subsection C of Section 14-3-2 NMSA 1978)~~

~~(2) The following specific types of materials are non-records:~~

~~(a) extra copies of correspondence;~~

~~(b) documents preserved only for convenience of reference;~~

~~(c) blank forms/books that are outdated;~~

~~(d) materials neither made nor received in pursuance of statutory requirements nor in connection with the functional responsibility of the office/agency;~~

~~(e) preliminary drafts of letters, reports, and memoranda that do not represent significant basic steps in preparation of records;~~

~~(f) shorthand notes, steno tapes, mechanical recordings that have been transcribed, except where noted on agency retention schedules;~~

~~(g) routing and other interdepartmental forms which are not significant evidence of the activity concerned and do not otherwise have value as described above;~~

~~(h) stocks of publications already sent to archives and processed documents preserved for supply purposes only;~~

~~(i) form and guide letters, sample letters, form paragraphs; [and]~~

~~(j) subject files, including copies of correspondence, memoranda, publications, reports and other information received by agency and filed by subject (also referred to as reading files or information files).~~

~~D. Records retention and disposition schedule:~~ ~~An official rule issued by the commission of public records which identifies the general and specific public records of state government and sets the minimum period of legal retention by record classification or type.~~

~~E. Custodial agency:~~ ~~The agency originating a public record.~~

~~F. Records liaison:~~ ~~The individual in the custodial agency responsible for authorizing the destruction of records. Subsection G of Section 14-3-4 NMSA 1978~~

~~G. Technology sensitive media:~~ ~~Any media created by any process or system that employs a mechanical, photo-optical, magnetic, electronic or other technological device for producing or reproducing records~~.]

A. "Administrator" means the state records administrator and the individual responsible for carrying out the purposes of the Public Records Act, specifically Section 14-3-15 NMSA 1978. "The official custodian and trustee for the state of all public records and archives of whatever kind which are transferred to him from any public office of the state or from any other source" (Section 14-3-6 NMSA 1978). The state records administrator has the overall administrative responsibility for carrying out the purposes of the Public Records Act and is the director of the New Mexico state records center and archives.

B. "Agency" means any state agency, department, bureau, board, commission, institution or other organization of the state government, including district courts. Sections 14-3-2 and 14-3-15 NMSA 1978.

C. "Archives" means the New Mexico state archives the entity responsible for selecting, preserving, and making available permanent records.

D. "Commission of public records" means the governing body of the NM state records center and archives that was created by an Act of the 24th Legislature of New Mexico convened January 13, 1959 (Sections 14-3-1 to 14-3-16, NMSA 1978). The commission is composed of: the attorney general; the secretary of state; the secretary of the NM general services department; the state auditor; the state law librarian; the director of the museum of New Mexico; and a recognized, professionally trained historian in the field of New Mexico history, resident in New Mexico, and appointed by the governor for a term of six years.

E. "Computer" means an electronic device designed to accept data (input), perform prescribed mathematical and logical operations at high speed (processing), and supply the results of these operations (output). This includes, but is not limited to, mainframe computers, minicomputers, and microcomputers, personal computers, portable computers, pocket computers, tablet computers, telephones capable of storing information, PDAs, and other devices.

F. "Custodial agency" means the agency responsible for the maintenance, care, or keeping of public records, regardless of whether the records are in that agency's actual physical custody and control.

G. "Custodian" means the person (guardian) responsible for the maintenance, care, or keeping of a public body's records, regardless of whether the records are in that person's actual physical custody and control. The statutory head of the agency using or maintaining the records or his designee.

H. "Custody" means the guardianship or records, archives, and manuscripts, which may include both physical possession (protective responsibility) and legal title (legal responsibility).

I. "Destruction" means the disposal of records of no further value by shredding, burial, incineration, pulping, electronic overwrite, or some other process, resulting in the obliteration of information contained on the record.

J. "Electronic records" means records whose informational content has been encoded and recorded on a medium like magnetic tape, drums, discs, or punched paper tape and can be retrieved by finding aids known as software documentation. The encoded information is retrievable only with the help of a computer.

K. "Non-records or non-essential records" means records listed on a records retention schedule for routine destruction, the loss of which presents no obstacle to restoring daily business. The following specific types of materials are non-records: extra copies of correspondence documents preserved only for convenience of reference blank forms or books which are outdated materials neither made nor received in pursuance of statutory requirements nor in connection with the functional responsibility of the office or agency preliminary and non-final drafts of letters, reports, and memoranda which may contain or reflect the working or deliberative process by which a final decision or position of the agency, board, department, or subdivision thereof is reached shorthand notes, stenographic tapes, mechanical recordings which have been transcribed, except where noted on agency retention schedules routing and other interdepartmental forms which are not significant evidence of the activity concerned and do not otherwise have value as described above stocks of publications already sent to archives and processed documents preserved for supply purposes only form and guide letters, sample letters, form paragraphs subject files, including copies of correspondence, memo-

randa, publications, reports, and other information received by agency and filed by subject (also referred to as reading files or information files)

L. "Permanent records" means records considered being unique or so valuable in documenting the history or business or an organization that they are preserved in an archives.

M. "Public records" means all books, papers, maps, photographs, or other documentary materials, regardless of physical form or characteristics, made or received by any agency in pursuance of law or in connection with the transaction of public business, preserved or appropriate for preservation, by the agency or its legitimate successor as evidence of the organization, functions, policies, decisions, procedures, operations or other activities or the government, or because of the informational and historical value of data contained therein (Section 14-3-2 NMSA 1978).

N. "Records" means information preserved by any technique in any medium now known, or later developed, that can be recognized by ordinary human sensory capabilities either directly or with the aid of technology (1.13.70 NMAC).

O. "Records center" means a facility designed and constructed to provide low-cost, efficient storage and reference service on records that have become inactive but have not reached their disposition date. The state records center, as defined by Subsection E of Section 14-3-2 NMSA 1978, is the "...central records depository which is the principal state facility for the storage, disposal, allocation or use of non-current records of agencies, or materials obtained from other sources."

P. "Records custodian" means the statutory head of the agency or his or her designee.

Q. "Records liaison" means the individual in the custodial agency designated by the records custodian to cooperate with, assist, and advise the state records administrator in the performance of the administrator's duties (Section 14-3-4 NMSA 1978). The records liaison in an agency is responsible for implementing the records retention and disposition schedules within his or her agency. The records liaison is also responsible for authorizing the storage and or destruction of his or her agency's records.

R. "Records retention and disposition schedules" means the document that specifies actions for the retention and disposition of current, inactive, and non-current records series of an organization or agency.

S. "Records series" means file units, documents, or electronic records arranged according to a filing system or maintained as a unit because they relate to a particular subject or function, result from the same activity, have a particular form, or share some other relationship arising from their creation, receipt, or use.

[12-1-94; Rn, 1 NMAC 3.55, 5-15-97; 1.13.30.7 NMAC - Rn, 1 NMAC 3.2.50.1.7 & A, 6/30/2004]

1.13.30.8 DESTRUCTION OF PUBLIC RECORDS:

A. The state records center and archives is responsible for the timely and appropriate destruction of all public records.

B. The commission of public records hereby delegates the authority to order the routine destruction of public records, in accordance with an adopted records retention and disposition schedule, to the state records administrator.

C. The state records administrator shall prescribe the appropriate method of destruction of public records.

[12-1-94; Rn, 1 NMAC 3.55, 5-15-97; 1.13.30.8 NMAC - Rn, 1 NMAC 3.2.50.1.8, 6/30/2004]

1.13.30.9 METHODS OF DESTRUCTION:

~~[A. Destruction of non-records: Destruction of non-records is the sole responsibility of the custodial agency and does not require the prior approval of the state records administrator. That responsibility includes identifying whether the information is a non-record or a public record as identified in a record retention and disposition schedule. (If it's in a current retention schedule, it is a public record. If there is any doubt, treat it as a public record or contact the state records center and archives.) Non-records should be destroyed via approved method of destruction for that type of information. To ensure information is destroyed, use one of the following methods:~~

~~(1) witnessed incineration;~~

~~(2) witnessed dump site burial;~~

~~(3) recycling through bonded recycler;~~

~~(4) witnessed shredding;~~

~~(5) when there are no issues of security, it is appropriate to place non-records in trash bins or waste paper baskets.~~

~~B. Approval for destruction of public records: The destruction of public records must be approved by the state records administrator and may occur on-site at the custodial agency or through the state records center.~~

~~C. Agency destruction of public records: Agencies who choose to store public records for the life cycle of the records may either contact the state records center for pick up and destruction or they may elect to use the following procedure (1 NMAC 3.2.50.1.9.3.1) for disposition of public records.~~

~~(1) Agency procedure for on-site destruction of public records.~~

~~(a) Agency shall request in writing permission to destroy public records. The request shall include:~~

~~(i) record retention schedule item no.;~~

~~(ii) item description of the records to be destroyed;~~

~~(iii) inclusive dates of the records to be destroyed; [and]~~

~~(iv) quantity of boxes, sacks, etc.~~

~~(b) The state records administrator shall review and, if appropriate, order in writing the transfer to archives or the destruction of the public records.~~

~~(c) Once written permission has been received, agency shall destroy the records via approved method of destruction:~~

~~(i) witnessed incineration~~

~~(ii) witnessed dump site burial~~

~~(iii) witnessed shredding~~

~~(iv) recycling through bonded recycler~~

~~(d) Agency shall certify destruction in writing and submit certification to the state records administrator. For both legal and audit purposes, the agency should retain a copy of the certification for its file. (Appendix 1)~~

~~(2) Agency procedure for records center destruction.~~

~~(a) The records liaison officer shall prepare and submit a request for pick up and destruction (scrap paper or records) form SRC-2 to the state records administrator. (Appendix 2)~~

~~(b) The state records administrator shall review a request, and, if appropriate, order in writing either the transfer to archives or the destruction of the public records.~~

~~D. Records center destruction of public records.~~

~~(1) The state records center will effect the timely and efficient destruction of public records which have met their retention period and have been released by the agency's records liaison.~~

~~(a) The state records center shall notify custodial agencies of records that have been stored for the scheduled retention period.~~

~~(b) The state records center will schedule, at least quarterly, the destruction of all public records which have been stored for the scheduled retention period.~~

~~(2) Custodial agencies receiving~~

~~notification of records eligible for destruction shall review the report of records to be destroyed.~~

~~(a) The agency shall notify the state records center of any records scheduled for destruction which must be held and shall cite appropriate reason; e.g., pending litigation, audit in process, audit pending, etc.~~

~~(b) The agency shall approve destruction in writing.~~

~~(3) The state records center procedure for destruction of records stored at the records center or delivered to the records center for destruction shall be to:~~

~~(a) prepare a report of records to be destroyed for review by the archives division and approval by the state records administrator;~~

~~(b) direct the archives division to review and separate records for further review;~~

~~(c) obtain an order by the state records administrator for the routine destruction of public records.~~

~~(d) destroy records by:~~

~~(i) bonded recycler for public records without confidentiality requirements;~~

~~(ii) witnessed shredding for confidential records only;~~

~~(e) prepare and/or file certificate of destruction (Appendix 1).~~

~~E. Destruction of paper records in alternative media. Destruction of paper records converted to alternative media shall comply with the applicable standards to ensure reliability and authenticity prior to their destruction.~~

~~(1) Destruction of paper public records converted to microfilm.~~

~~(a) Agencies must meet all requirements of 1 NMAC 3.2.60.1 prior to destruction of microfilmed paper records.~~

~~(b) Agencies must comply with 1 NMAC 3.2.50.1.9.3 for on-site destruction of public records or request pick up and destruction by the state records center.~~

~~(2) Destruction of paper records converted to electronic or technology sensitive media.~~

~~(a) Agencies must meet all provisions of 1 NMAC 3.2.70.1 prior to destruction of converted paper records.~~

~~(b) Agencies must comply with 1 NMAC 3.2.50.1.9.3 for on-site destruction of public records or request pick up and destruction by the state records center.~~

~~F. Destruction of microfilm. When destruction of microfilm is required, and the microfilmed record has met its required retention period, destruction of the microfilm will be accomplished by witnessed shredding.~~

~~G. Destruction of electronic or technology sensitive media. When destruction of a record in electronic or technology sensitive media is required.~~

~~(1) Non-records: See Paragraph 9.1 of this rule.~~

~~(2) Public records shall be deleted or destroyed in accordance with a current retention schedule. See Paragraph 9.2 and Sub-Section 9.3 of this rule.~~

~~(3) Confidential or restricted records shall be overwritten on all machine readable media on which it is stored, or the storage media may be physically destroyed.~~

~~(4) Supporting documentation (e.g., audit trails and results, certification records, etc.) should be disposed of in conjunction with the record(s) they support.~~]

A. Destruction of non-records: Destruction of non-records is the sole responsibility of the custodial agency and does not require the prior approval of the state records administrator. That responsibility includes identifying whether the information is a non-record or a public record as identified in a record retention and disposition schedule. (If it's in a current retention schedule, it is a public record. If there is any doubt, treat it as a public record or contact the state records center and archives.) Non-records may be destroyed via the approved method of destruction for that type of information. To ensure information is destroyed, use one of the following methods:

(1) witnessed incineration;

(2) witnessed dumpsite burial;

(3) recycling through bonded recycler;

(4) witnessed shredding; or

(5) when there are no issues of security, it is appropriate to place non-records in trash bins or waste paper baskets.

B. Approval for destruction of public records: The destruction of public records must be approved by the state records administrator and may occur on-site at the custodial agency or through the state records center.

C. Agency destruction of public records: Agencies who choose to store public records for the life cycle of the records may either contact the state records center for destruction or they may elect to use the following procedure (Paragraph 1 of this subsection) for disposition of public records.

(1) Agency procedure for on-site destruction of public records.

(a) Agency shall request in writing permission to destroy public records. The request shall include:

(i) record retention and disposition schedule item number;

(ii) item description of the records to be destroyed;

(iii) inclusive dates of the records to be destroyed (or disposition trigger date); and

(iv) quantity of boxes, sacks, etc.

(b) The state records administrator shall review and, if appropriate, order in writing the transfer to archives or the destruction of the public records.

(c) Once written permission has been received, agency shall destroy the records via approved method of destruction:

(i) witnessed incineration;

(ii) witnessed dumpsite burial;

(iii) witnessed shredding; or

(iv) recycling through a bonded recycler

(d) Agency shall certify the destruction in writing and submit the certification to the state records administrator. For both legal and audit purposes, the agency should retain a copy of the certification for its file.

(2) Agency procedure for records center destruction.

(a) The records liaison officer shall prepare and submit a request for disposition to the state records administrator.

(b) The state records administrator shall review a request and, if appropriate, order in writing either the transfer to archives or the destruction of the public records.

D. Records center destruction of public records.

(1) The state records center will effect the timely and efficient destruction of public records that have met their retention period and have been released by the agency's records liaison.

(a) The state records center shall notify custodial agencies of records that have been stored for the scheduled retention period.

(b) The state records center will schedule, at least quarterly, the destruction of all public records that have been stored for the scheduled retention period.

(2) Custodial agencies receiving notification of records eligible for destruction shall review the report of records to be destroyed.

(a) The agency shall notify the state records center of any records scheduled for destruction which must be held and shall cite appropriate reason; e.g., pending litigation, audit in process, audit pending, etc.

(b) The agency shall approve destruction in writing.

(3) The state records center procedure for destruction of records stored at the records center or delivered to the records center for destruction shall be to:

(a) prepare a report of records to

be destroyed for review by the archives division and approval by the state records administrator;

(b) direct the archives division to review and separate records for further review;

(c) obtain an order by the state records administrator for the routine destruction of public records.

(d) destroy records through:

(i) bonded recycler for public records without confidentiality requirements; and

(ii) witnessed shredding for confidential records only.

(e) direct the recycler to prepare and submit to the state records center and archives a certificate of destruction showing the date of destruction, the method of destruction, the names of person or persons that witnessed the destruction, and the signature or signatures of the person or persons who witnessed the destruction.

E. Destruction of paper records in alternative media. Destruction of paper records converted to alternative media shall comply with the applicable standards to ensure reliability and authenticity prior to their destruction.

(1) Destruction of paper public records converted to microfilm.

(a) Agencies must meet all requirements of 1.14.2 NMAC prior to destruction of microfilmed paper records.

(b) Agencies must comply with Subsection C of this section for on-site destruction of public records or request destruction by the state records center.

(2) Destruction of paper records converted to electronic or technology sensitive media.

(a) Agencies must meet all provisions of 1.13.70 NMAC prior to destruction of converted paper records.

(b) Agencies must comply with Subsection C of this section for on-site destruction of public records or request pick up and destruction by the state records center.

F. Destruction of microfilm. When destruction of microfilm is required and the microfilmed record has met its required retention period, destruction of the microfilm will be accomplished by witnessed shredding.

G. Destruction of electronic or technology sensitive media. When destruction of a record in electronic or technology sensitive media is required.

(1) Non-records: See Subsection A of this section.

(2) Public records shall be destroyed in accordance with a current retention schedule. See Subsections B and C of this section.

(3) Supporting documentation (e.g., audit trails and results, certification records, etc.) should be disposed of in conjunction with the record(s) they support.

H. The destruction of an electronic record can have two possible avenues, either the information and the record media are destroyed or the information is obliterated because the media for electronic records can remain useful and only the information needs to be destroyed. An agency shall select the best method for the destruction of an electronic record based on the retention of the record, the media and the nature or sensitivity of the information. For a local hard disk, methods one and two that follow should be sufficient. For other magnetic, optical, or solid-state storage media, agency information systems staff should be consulted. Agencies shall select from the following methods of destruction:

(1) erasure from electronic media and all back up media;

(2) emptying of electronic trash receptacle;

(3) witnessed overwriting of reusable magnetic media multiple times as recommended by the US department of defense;

(4) witnessed degaussing of the magnetic media; or

(5) witnessed physical destruction of the media as recommended by the US department of defense.

[12-1-94; Rn, 1 NMAC 3.55, 5-15-97; 1.13.30.9 NMAC - Rn, 1 NMAC 3.2.50.1.9 & A, 6/30/2004]

[Subsection H of Section 1.13.30.9 NMAC was developed from information contained in *U.S. department of defense 5220-m, national industrial security program*.]

NEW MEXICO COMMISSION OF PUBLIC RECORDS

This is an amendment of 1.13.40 NMAC Accession of Public Records by the State Records Center and Archives, Private Collection Development Policy. Amended sections include 3 and 5-16. Sections 17 - 20 are new. This rule was renumbered from 1 NMAC 3.2.40.5. The effective date is June 30, 2004.

TITLE 1 GENERAL GOVERNMENT ADMINISTRATION
CHAPTER 13 PUBLIC RECORDS
PART 40 [~~ACCESSION OF PUBLIC RECORDS BY THE STATE RECORDS CENTER AND ARCHIVES,~~] PRIVATE COLLECTION DEVELOPMENT POLICY

1.13.40.1 ISSUING AGENCY: Commission of Public Records - State Records Center and Archives (SRCA)
[4/15/98; 1.13.40.1 NMAC - Rn, 1 NMAC 3.2.40.5.1, 06/30/04]

1.13.40.2 SCOPE: Potential donors of archival material
[4/15/98; 1.13.40.2 NMAC - Rn, 1 NMAC 3.2.40.5.2, 06/30/04]

1.13.40.3 S T A T U T O R Y AUTHORITY:

[~~A. Section 14-3-4 NMSA 1978. Duties and powers of commission. The commission of public records is empowered to adopt and publish rules and regulations to carry out the purposes of the Public Records Act.~~

~~B.~~] Section 1-3-5 NMSA 1978. Gifts, donations and loans. The commission may receive either as donations or loans from private sources, other state agencies, counties, municipalities, the federal government, and other states or countries, archival materials of any physical form or characteristics which are deemed to be of value to the state and the general public for historical reference or research purposes. Acceptance of both donations and loans shall be at the discretion of the commission upon advice of the administrator. Accepted donations shall become, without qualification or restriction, the property of the state of New Mexico. Loans shall be accepted only after a written agreement covering all terms and conditions of each loan has been signed by the lender, the administrator and approved by the commission.
[4/15/98; 1.13.40.3 NMAC - Rn, 1 NMAC 3.2.40.5.3 & A, 06/30/04]

1.13.40.4 D U R A T I O N : Permanent.
[4/15/98; 1.13.40.4 NMAC - Rn, 1 NMAC 3.2.40.5.4, 06/30/04]

1.13.40.5 EFFECTIVE DATE: April 15, 1998 unless a later date is cited at the end of a section.
[4/15/98; 1.13.40.5 NMAC - Rn, 1 NMAC 3.2.40.5.5 & A, 06/30/04]

1.13.40.6 OBJECTIVE: To provide criteria for evaluating documents for acquisition from sources other than state agencies which will enhance the current body of archival collections. Archival materials collected [~~should~~] shall support New Mexico history in its broad context with original source materials which document government policy, political leadership, the legislative process, citizenship, land ownership, water rights and family histories.
[4/15/98; 1.13.40.6 NMAC - Rn, 1 NMAC 3.2.40.5.6 & A, 06/30/04]

1.13.40.7 DEFINITIONS:

A. **Access** [~~The authority to obtain information from or to perform research in archival collections held by the state records center and archives~~] means the availability of archives, records, or manuscripts in terms of physical condition, legal permission and legal entry.

B. **Accession** [~~The transfer of physical and legal custody of archival materials to the state records center and archives. Also refers to an accumulation of records transferred to the state records center and archives~~] means a term used as both a noun and a verb for the act and procedures involved in a transfer of legal title and the taking of records or papers into the physical custody of an archival agency, records center or manuscripts repository and the materials involved in such a transfer.

C. **Acquisition** means the process of identifying and acquiring by donation or purchase archival materials from sources outside of state government.

D. **Administrator** means the state records [~~administrator/director~~] administrator, who also serves as the director of the state records center and archives appointed by the commission of public records.

E. **Archival material** means the non-current records or papers of an individual, family, organization or institution preserved because of their continuing historical, informational or intrinsic value.

F. **Archives** means the permanent records of the state of New Mexico, which may include government and private collections of the Spanish, Mexican, territorial and statehood periods, assessed to have significant historical value to warrant their preservation by the state of New Mexico. [~~Also~~] The term also refers to the organizational unit of the SRCA storing these records.

G. **Artifact** [~~an object produced by man~~] means an object of archaeological interest, produced by man.

H. **Collection policy** [~~The policy established by the SRCA concerning the selection of archival materials to be acquired either through donation or purchase based on subject areas, time periods, geographical areas, and physical formats~~] means a statement of policy adopted by an archival agency, records center, or manuscripts repository to guide its accessioning and de-accessioning decisions in order to carry out its formal mission.

I. **Collection** [~~A body of archival materials relating to an individual, family, or organization~~] means an artificial accumulation of documents brought together on the basis of some common characteristic, a grouping of records created by private individuals and organizations or the total holdings of a manuscript repository.

J. **De-accession** [~~the removal of physical and legal custody of archival materials from the state records center and archives~~] means the act, or the materials involved in the act, of a transfer out of the custody of an archives and is the opposite of accession.

K. **Deed of gift** means a legal document accomplishing the donation of archival materials to the SRCA through transfer of title.

L. **Documents** means any recorded information regardless of media, including books, correspondence, reports, maps, manuscripts, microforms, photographs, sound recordings, motion pictures, architectural drawings and electronic files.

M. **Donation** means a gift.

N. **Material culture** means physical objects used by a society other than documents.

O. **Personal papers** means a natural accumulation of documents created or accumulated by an individual or family belonging to him or her and subject to his or her disposition.

P. **Private collection** means a body of archival materials relating to an individual, family, organization or institution acquired through donation or purchase rather than in accordance with state statute.

Q. **Record** [~~All~~] means recorded information, regardless of media or characteristics, made or received and maintained by an institution.

R. **Repository** refers to the SRCA as a facility where documents are deposited, donated, or stored for safekeeping.

S. **Researcher** means a person who has applied for access to public records or private collections in accordance [~~to~~] with 1.13.11 NMAC.

[4/15/98; 1.13.40.7 NMAC - Rn, 1 NMAC 3.2.40.5.7 & A, 06/30/04]

1.13.40.8 BACKGROUND: The commission of public records (commission) was created by the New Mexico legislature in 1959 and assigned the responsibility for the care, custody, preservation and disposition of public records created by state, county and local governments. The state records center and archives (SRCA) is the facility established by the commission to fulfill its statutory mandate. The SRCA currently houses public records from the executive, legislative and judicial branches of state government, including documents dating from New Mexico's Spanish (1621-1821), Mexican (1821-1846), and territorial (1846-1912) periods of history. The archives also maintains an extensive collection of personal papers which have been donated by families, attorneys, political figures and benevolent organizations. A collection policy is a standard archives practice for publicly declaring an archives's intent [~~for breadth and depth of material it will collect within~~] to collect documents that pertain to certain subject areas, geographical areas, languages, or physical forms of material.

[4/15/98; 1.13.40.8 NMAC - Rn, 1 NMAC 3.2.40.5.8 & A, 06/30/04]

1.13.40.9 USES OF PRIVATE COLLECTIONS IN STATE REPOSITORY: Private collections support the SRCA's mission to protect, preserve and provide access to public records which document the rights and history of the people of New Mexico, and to provide information to and about government. In addition, collections support research, exhibit and public outreach.

A. Research: Archival collections provide resources for scholars and researchers studying government and history by strengthening and augmenting existing collections in the fields of New Mexico government and history.

B. Exhibits: Archival collections support exhibit programs that interpret New Mexico's heritage to statewide, national and international visitors.

(1) Exhibits may be prepared from private collections and displayed in the archives.

(2) Documents from private collections may also be loaned to other institutions for exhibition with the approval of the commission.

(3) Reproductions and duplicates of documents from private collections may be used for exhibits outside the agency with permission of the administrator.

C. Outreach: The SRCA [~~will~~] shall promote the use of private collections through increased public awareness of the nature and importance of the archival materials. The acquisition of collections may be publicized in local newspapers and agency publications.

[4/15/98; 1.13.40.9 NMAC - Rn, 1 NMAC 3.2.40.5.9 & A, 06/30/04]

1.13.40.10 ACQUISITIONS:

A. Purchases. Purchase of documents may be financed through monetary donations made to the SRCA and [~~are~~] is restricted to materials which meet private collection policy criteria as stated in 1.13.40.11 NMAC.

B. Loans.

(1) The commission [~~will~~] shall not accept materials without a signed loan agreement.(SRC form 97-34), 1.13.40.17 NMAC.

(2) A loan agreement shall not exceed a period of five years without

review.

(3) Loaned material [~~will~~] shall be maintained intact, subject to the terms and conditions of the loan agreement.

C. Donations.

(1) Donations [~~are~~] shall be subject to acceptance by the commission of public records based on collection policy criteria as stated in 1.13.40.11 NMAC.

(2) The commission [~~will~~] shall not accept materials without a legal transfer of title, executed by a deed of gift as described in (SRC form 77) 1.13.40.18 NMAC.

(3) Donations accepted by the commission shall become the unqualified property of the state of New Mexico.

[4/15/98; 1.13.40.10 NMAC - Rn, 1 NMAC 3.2.40.5.10 & A, 06/30/04]

1.13.40.11 COLLECTION STRENGTHS, WEAKNESSES AND PRIORITIES: Collections maintained by the SRCA are strongest in the area of government administration. However, through the centuries many government records for the Spanish, Mexican and territorial periods have been pilfered or destroyed. Consequently there are gaps within collections. Prior to the creation of the SRCA in 1960 and the establishment of a records management program for the retention, preservation and disposition of public records, state agencies and elected officials disposed of records at will. Therefore there are many discontinuances within the public records maintained for state government for the years 1912 to 1959. The SRCA would like to collect archival materials that supplement current collections and meet the agency's objective.

A. Identified collection strengths. [~~The~~] Since its creation in 1960, the SRCA has actively collected the state's official permanent government records [~~since its creation in 1960~~]. In that year the state archives, in its capacity as the official custodian of the state archives, acquired from the historical society of New Mexico the Spanish, Mexican and territorial archives of New Mexico [~~, in its capacity as the official custodian of the state archives~~]. These collections provide important documentation in the following subjects and time periods.

(1) Spanish period. Administrative, civil, judicial, military and land grant records of the Spanish government in New Mexico for the years 1680-1821.

(2) Mexican period. Administrative, civil, judicial, military, legislative and land grant records of the Mexican government in New Mexico for the years 1821-1846.

(3) Territorial period. Administrative, judicial, military and legislative records of the territory of New Mexico for the years 1889-1912.

(4) Statehood. Executive and legislative documents from 1960 to the present.

B. Identified collection weaknesses.

(1) Spanish colonial documents, 1598 -1680. As a result of the 1680 Pueblo Revolt, administrative, civil, judicial, military and ecclesiastical records for this period were destroyed. The SRCA has very few documents for this time period.

(2) Spanish period documents, 1680 -1821. Many documents for this time period have been lost as a result of theft or disasters, either man-made or natural.

(3) Military and territorial periods, 1846 -1889. Administrative, judicial, military and legislative records from 1846 to1889 were removed by officials upon completion of their term of office. Therefore the SRCA has a sparse collection of governors and territorial officials papers.

(4) Statehood government records, 1912 -1959. Executive, legislative, judicial and military records from 1912 to 1960.

(5) Congressional papers, 1912-present. The SRCA has not actively collected the papers of [~~New Mexico legislators and~~] U.S. senators and representatives from New Mexico.

(6) County records, 1850-1912. Many records kept by territorial county officials have been lost through theft and disasters (man-made and/or natural). Counties are not required by statute to transfer permanent records to the SRCA.

C. Identified collection priorities. The SRCA places major emphasis on acquiring archival collections relating to any of the following subjects which would enhance existing collections.

(1) Administrative government documents, 1598 -1959. Correspondence, decrees, orders, and reports.

(2) Military documents, 1598 - 1959. Enlistment papers, muster rolls, service records.

(3) Civil documents, 1598 -1912. Wills and settlement of estates, land grant petitions, deeds and conveyances of property.

(4) Ecclesiastical documents, 1598 -1846. Inquisition and ecclesiastical court reports, church censuses, reports regarding civil and military matters.

(5) County documents, 1850 - 1912. Probate records, county commission journals, county clerk record books, sheriff, treasurer and justice of the peace record books.

(6) Judicial documents, 1598 - 1912. Judicial proceedings, criminal and civil docket books, record books and case files.

(7) Personal papers of New Mexico legislators and U.S. congressmen, 1850 - present.

(8) Maps, 1598 -1950. Expedition, land grant, military reconnaissance, land use, road and highway maps, postal route, railroad and USGS quadrangle maps.

(9) Photographs, 1840 -1950. Historical buildings, historical events and celebrations, political figures, Indian pueblos and reservations.

(10) Motion picture film. Film documenting or depicting historical events and celebrations, buildings, political figures and state government functions. [~~Nitrate based film will generally not be accepted.~~]

D. Geographical areas and chronological periods collected. The SRCA places emphasis on acquiring materials pertaining to localities within the geographical boundaries of the state of New Mexico for the period 1598 to the present. However, archival materials pertaining to the areas of southern Colorado, eastern Arizona, west Texas and northern Chihuahua, which were part of New Mexico during the years 1598 to 1862, are also collected. All materials [~~must~~] shall meet the criteria for acquisition as stated in 1.13.40 NMAC.

E. Languages, other than English, collected. Documentary materials in any language which meet the criteria for acquisition as stated in 1.13.40 NMAC will be collected.

F. Physical forms of material collected.

(1) Manuscripts. Handwritten or typed documents, including a letterpress or carbon copy.

(2) Personal papers. Documents created or accumulated by an individual or family, subject to donor's disposition.

(3) Books. [~~Must pertain~~] Pertaining to New Mexico history, politics, and government, including Spanish dictionaries published prior to 1900.

(4) Media. The SRCA will not actively solicit any form of non-print media which it cannot support. However, older collections may contain vinyl records, film, cassettes and electronic records. Contemporary collections may also contain audio and videotapes and collections in the future may contain computer, optical, compact or other forms of disks. Therefore non-print media [~~will~~] shall also be accepted.

(5) Government publications. The SRCA is a depository for state publications. Government publications that are accessioned as part of a collection [~~will~~] shall only be retained if they inherently relate to the papers in that collection.

(6) Serials. Publications issued at

regular intervals [~~will~~] shall be collected if they relate to existing collections, New Mexico history or state government.

(7) Newspapers. Extended runs of newspapers [~~will~~] shall generally not be collected. However some single issues which have importance in relation to individual collections may be retained in association with those collections.

(8) Microforms. Microforms may be included as part of a collection if they meet the SRCA acquisition criteria.

(9) Maps. See Paragraph (8) of Subsection C of 1.13.40.11 NMAC. Hand-copied, print, microfilm, blueprint, aerial photographs and computer-assisted maps.

(10) Photographs. See Paragraph (9) of Subsection C of 1.13.40.11 NMAC. Generally all photographic processes will be accepted [~~, except cellulose nitrate negatives~~].

(11) Motion Picture Film. See Paragraph (10) of Subsection C of 1.13.40.11 NMAC [~~16mm and VHS~~]. Moving image materials including film, magnetic tape, and digital formats.

[4/15/98; 1.13.40.11 NMAC - Rn, 1 NMAC 3.2.40.5.11 & A, 06/30/04]

1.13.40.12 LIMITATIONS AND EXCLUSIONS:

A. The commission of public records [~~will~~] shall generally NOT accept:

(1) materials that are not pertinent to New Mexico government [~~and/or~~] or history;

(2) materials pertaining to New Mexico of no historical, informational or evidential value;

(3) materials to which the donor does not have legal title;

(4) duplications of original material under other ownership or custody with the exception of scholarly research material;

(5) artifacts or material culture;

B. Unsolicited donations:

(1) will be evaluated in terms of their suitability and relationship to other holdings in the archives;

(2) with the approval of the administrator unsolicited donations that are not suitable or pertinent will be returned to the donor; see 1.18.369 NMAC.

(3) The commission has the right to refuse private collections inappropriate to its holdings transferred by will.

C. Closed collections and restrictions.

(1) The commission [~~will~~] shall not accept collections that are permanently closed to public access by the donor.

(2) The commission may accept collections that are temporarily closed by the donor to public access for a reasonable period of time.

(3) Access to classified and confidential materials [~~are~~] shall be subject to state and federal laws.

D. Monetary appraisal of private collections. The commission and the SRCA are prohibited by law from appraising the monetary value of donations. Pursuant to the Deficit Reduction Act of 1984, PL 98-369

[4/15/98; 1.13.40.12 NMAC - Rn, 1 NMAC 3.2.40.5.12 & A, 06/30/04]

1.13.40.13 COOPERATION WITH OTHER REPOSITORIES: The SRCA recognizes that other institutions collect in the same or overlapping areas, and it is further [~~recognized~~] recognizes that other institutions may be [~~a~~] more appropriate [~~repository~~] repositories for material donated to the SRCA. Therefore, opportunities to acquire artifacts, cultural material and other textural materials not covered by the collection policy [~~will~~] shall be referred to an appropriate repository.

[4/15/98; 1.13.40.13 NMAC - Rn, 1 NMAC 3.2.40.5.13 & A, 06/30/04]

1.13.40.14 ACCESS TO PRIVATE COLLECTIONS BY RESEARCHERS: The policy of the SRCA is to make all materials available to researchers on equal terms, subject to the appropriate care and handling of materials and within limitations set by the donor in the deed of gift. See 1.13.11 NMAC, Research in the New Mexico Archives.

A. Donors. Donors [~~will~~] shall have access to their donated collections during regularly scheduled hours.

B. General public. With registration, any researcher may use the collections during regularly scheduled hours, subject to agency guidelines.

C. State, federal, county and municipal employees. With registration, employees may use collections during regularly scheduled hours, subject to agency guidelines.

D. Access to materials. The SRCA staff [~~will~~] shall monitor the use of materials by researchers at all times in order to guard the safety and security of materials.

E. Guidelines. Researchers [~~will be expected to~~] shall sign a visitors log, (SRC form 64), as described in 1.13.40.20 NMAC; follow the guidelines for use of documents, 1.13.11.9 NMAC; and complete a user registration form (SRC form 96-20), as described in 1.13.40.19 NMAC.

[4/15/98; 1.13.40.14 NMAC - Rn, 1 NMAC 3.2.40.5.14 & A, 06/30/04]

1.13.40.15 STATEMENT OF DE-ACCESSIONING POLICY:

A. Duplicates and material that do not reflect the collection policy of the SRCA may be deaccessioned, subject to terms of acquisition, agency policy and state law.

B. Deaccessioned items may be transferred to another repository, returned to the donor [~~/~~] or donor's family or discarded.

C. Preservation policies regarding the care and storage of deteriorating materials, and reformatting of fragile material to a more stable media, may require disposal or return of original documents.

D. The SRCA reserves the right to deaccession any materials within its collections subject to the terms of acquisition and the notification of the donor or [~~his/her~~] his or her heirs.

[4/15/98; 1.13.40.15 NMAC - Rn, 1 NMAC 3.2.40.5.15 & A, 06/30/04]

1.13.40.16 REVISION OF REGULATION:

A. The SRCA reserves the right to make changes to this regulation as seems reasonable and prudent.

B. Efforts [~~will~~] shall be made to conform to the intent of the agreement made between the archives and the donor at the time of the accession.

[4/15/98; 1.13.40.16 NMAC - Rn, 1 NMAC 3.2.40.5.16 & A, 06/30/04]

1.13.40.17 REQUIREMENTS FOR INCOMING LOAN AGREEMENT, SRC FORM 97-34:

A. This form delineates the conditions for an organization or individual to loan their records to the SRCA. Information contained on the form shall include, but shall not be limited to, the following:

(1) description of documents or collections, including;

(a) title of documents or collections;

(b) date of documents or collections;

(2) terms and conditions of loan agreement; and

(3) term of loan, including;

(a) beginning date of loan; and

(b) termination date of loan

B. This form shall require of the requesting organization the following information:

(1) name of organization or individual;

(2) address of organization or individual;

(3) phone number of organization or individual; and

(4) signature of lender.

C. This form shall require

the following signatures from the commission of public records - SRCA:

(1) signature of the archives and historical services division director;

(2) signature of the state records administrator; and

(3) signature of the chairman of the commission of public records.

D. Signatures of the archives and historical services division director and the lending organization or individual signify: an agreement between the two entities to the conditions set forth in this form and are required to be notarized.

E. Signatures of the state records administrator and the chairman of the commission of public records signify approval of the loan agreement.

[4/15/98, 1.13.40.17 NMAC - Rn, 1 NMAC 3.2.40.5, SRC Form 96-34 & A, 06/30/04]

1.13.40.18 REQUIREMENTS FOR DEED OF GIFT, SRC FORM 77:

A. This form delineates the legal transfer of ownership of documents or collections from the donor to the commission of public records - SRCA. Information contained on the form shall include, but is not limited to, the following:

(1) name of donor;

(2) address of donor;

(3) description of donated materials;

(4) any access restrictions; and

(5) terms of donation.

B. Signatures of the archives and historical services division director and the donor signify: an agreement between the two entities to the conditions set forth in this form and are required to be notarized.

C. Signatures of the state records administrator and the chairman of the commission of public records signify approval of the deed of gift.

[4/15/98, 1.13.40.18 NMAC - Rn, 1 NMAC 3.2.40.5, SRC Form 77 & A, 06/30/04]

1.13.40.19 REQUIREMENTS FOR USER REGISTRATION FORM, SRC FORM 96-20:

A. This form delineates the information required of the researcher to become a registered patron of the archives research rooms. All researchers shall complete this one time registration form before entry into the archives research rooms.

B. The form requests the following researcher information:

(1) name and signature of researcher;

(2) signature of parent or guardian of the researcher, as provided for in Subsection H of 1.13.11.8 NMAC.

(3) physical and email (if available) addresses of the researcher;

(4) telephone number of the researcher;

(5) user description of researcher;

(6) indication of the researcher's willingness to share research information with other researchers; and

(7) date.

C. The researcher's signature signifies that he has read the rules and procedures for using the public records held by the archives and historical services division of SRCA, and that he has agreed to abide by them.

[4/15/98, 1.13.40.19 NMAC - Rn, 1 NMAC 3.2.40.5, SRCA Form 96-20 & A, 06/30/04]

1.13.40.20 REQUIREMENTS FOR VISITOR'S LOG, SRC FORM 64:

A. This form delineates the information required of the researcher to perform research in the archives research rooms. All researchers shall complete this form upon arrival to and departure from the archives research rooms.

B. The form requests the following researcher information:

(1) printed full name of researcher;

(2) intended use;

(3) date;

(4) time in; and

(5) time out.

[4/15/98, 1.13.40.20 NMAC - Rn, 1 NMAC 3.2.40.5, SRCA Form 96-64 & A, 06/30/04]

HISTORY OF 1.13.40 NMAC: [RESERVED]

NEW MEXICO PUBLIC REGULATION COMMISSION

INSURANCE DIVISION

This is an amendment to 13 NMAC 11.2, Sections 1, 3, 5 and 10. This amendment will also renumber and reformat 13 NMAC 11.2 to 13.11.2 NMAC in accordance with the current New Mexico Administrative Code (NMAC) requirements effective, June 30, 2004.

13.11.2.1 ISSUING AGENCY: New Mexico [~~State Corporation Commission, Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269~~] Public Regulation Commission Insurance Division.

[7/1/97; 13.11.2.1 NMAC - Rn & A, 13 NMAC 11.2.1, 6/30/04]

13.11.2.3 STATUTORY AUTHORITY: Section 59A-2-9 and [~~59A-3-6~~]59A-16-3 NMSA 1978.

[10/13/88; 13.11.2.3 NMAC - Rn & A, 13 NMAC 11.2.3, 6/30/04]

13.11.2.5 EFFECTIVE DATE: October 13, 1988, unless a later date is cited at the end of a section [~~or paragraph. Repromulgated in NMAC format effective July 1, 1997~~].

[10/13/88, 7/1/97; 13.11.2.5 NMAC - Rn & A, 13 NMAC 11.2.5, 6/30/04]

13.11.2.10 REQUIREMENTS: A liability insurance policy as specified in Subsection B of 13.11.2.9 NMAC which contains a provision limiting legal defense costs shall be issued or renewed in this state only if the requirements of Subsections A and B of 13.11.2.10 NMAC are met, or if the requirement of Subsection C of 13.11.2.10 NMAC is met.

A. Legal defense costs charged against the stated limit of liability shall not exceed fifty percent (50%) of such limits and, except as authorized by Subsection B of 13.11.2.10 NMAC, the insurer shall assume any legal defense cost over the amount of percentage specified in the policy.

B. Legal defense costs charged against the deductible shall not exceed fifty percent (50%) of such deductible and, except as authorized by Subsection A of 13.11.2.10 NMAC, the insurer shall assume any legal defense cost over the amount or percentage specified in the policy in regard to such deductible.

C. The limitation specified in Subsections A and B of 13.11.2.10 NMAC [~~of this section~~]may be omitted if the policy provides that the insured shall have the option to:

(1) select the defense attorney or to consent to the insurer's choice of defense attorney, which consent shall not be unreasonably withheld;

(2) participate in, and assist in the direction of the defense of any claim with such participation and assistance not limiting the insurer's right to control the defense; and

(3) consent to a settlement, which consent shall not be unreasonably withheld.

[10/13/88; 13.11.2.10 NMAC - Rn & A, 13 NMAC 11.2.10 NMAC, 6/30/04]

NEW MEXICO DEPARTMENT OF PUBLIC SAFETY

TITLE 10 PUBLIC SAFETY AND LAW ENFORCEMENT
CHAPTER 5 STATE POLICE
PART 500 ADJUDICATORY PROCEEDINGS FOR COMMISSIONED NEW MEXICO STATE POLICE OFFICERS PURSUANT TO

NMSA 1978, SECTION 29-2-11C

10.5.500.1 ISSUING AGENCY: Department of Public Safety - State Police Division
[10.5.500.1 NMAC - N, 6-30-04]

10.5.500.2 SCOPE: All officers of the state police division of the New Mexico department of public safety holding a permanent commission.
[10.5.500.2 NMAC - N, 6-30-04]

10.5.500.3 STATUTORY AUTHORITY: Section 9-9-6 NMSA 1978 outlines the duties and general powers of the secretary of the department of public safety which include the power to make and adopt such reasonable procedural rules and regulations as may be necessary to carry out the duties of the department and its divisions. Section 29-2-1.1G defines the New Mexico state police board as meaning the secretary of the department of public safety. Section 29-2-22 NMSA 1978 assigns authority to the New Mexico state police board, i.e., the secretary of the department of public safety to promulgate rules and regulations for the purpose of carrying out the provisions of Section 29-2-1 NMSA 1978 through Section 29-2-29 NMSA 1978. Section 29-2-4 specifically requires the New Mexico state police board, i.e., the secretary of the department of public safety to promulgate rules and regulations governing employment and operating practices and related matters for the employees of the New Mexico state police. The New Mexico Administrative Procedures Act, Sections 12-8-1 through 12-8-25 provides for the adoption of an adjudicatory procedure as contemplated by Section 29-2-11C NMSA 1978.
[10.5.500.3 NMAC - N, 6-30-04]

10.5.500.4 DURATION: Permanent
[10.5.500.4 NMAC - N, 6-30-04]

10.5.500.5 EFFECTIVE DATE: June 30, 2004, unless a later date is cited at the end of a section.
[10.5.500.5 NMAC - N, 6-30-04]

10.5.500.6 OBJECTIVE: The objective of this rule is to provide a procedure for a full and fair adjudicatory hearing for a New Mexico state police officer holding a permanent commission who is facing disciplinary action as contemplated by Section 29-2-11C NMSA 1978.
[10.5.500.6 NMAC - N, 6-30-04]

10.5.500.7 DEFINITIONS:

A. "Commission" means the public safety advisory commission.

B. "Officer" means a New Mexico state police officer holding a permanent commission facing disciplinary action involving removal from office, demotion, or suspension for more than thirty (30) days.

C. "Parties" means the department of public safety and the officer.
[10.5.500.7 NMAC - N, 6-30-04]

10.5.500.8 ADOPTION AND MODIFICATION OF SPECIFIC SECTIONS OF THE ADMINISTRATIVE PROCEDURES ACT, SECTIONS 12-8-1 THROUGH 12-8-25 NMSA 1978: The secretary of the department of public safety adopts, as modified, to comport with the purposes of Sections 29-2-11C and 29-2-11D, the following sections of the Administrative Procedures Act: Sections 12-8-1B(1), (2) and (3); Sections 12-8-10C and 12-8-10D; Sections 12-8-11 through 12-8-16.
[10.5.500.8 NMAC - N, 6-30-04]

10.5.500.9 APPOINTMENT OF A HEARING OFFICER: For the purpose of providing a New Mexico state police officer subject to discipline as contemplated by Section 29-2-11C NMSA 1978 with a timely hearing, the commission shall appoint an independent hearing officer who is an attorney licensed to practice law in the state of New Mexico to preside over the hearing pursuant to Section 29-2-11C and these rules. The hearing officer's powers shall include administering oaths or affirmations to witnesses called to testify, taking testimony, examining witnesses, admitting or excluding evidence.
[10.5.500.9 NMAC - N, 6-30-04]

10.5.500.10 DISCOVERY DEADLINES: The parties will submit a list of proposed witnesses, together with the gist of testimony or the type of testimony expected to be elicited from each witness. The parties shall likewise be required to submit a list of exhibits it intends to introduce at the hearing. The parties shall produce for examination or copying any exhibits the parties anticipate using at the hearing. The witness and exhibit lists shall be made available to the parties and submitted to the hearing officer. Other discovery or pretrial conferences and procedures available in the district courts may be utilized upon demand by any party. The hearing officer shall issue a pre-trial order establishing discovery deadlines.
[10.5.500.10 NMAC - N, 6-30-04]

10.5.500.11 NOTICE: In this proceeding, the parties shall be afforded an opportunity for hearing after reasonable notice. The notice shall include:

A. a statement of the time place and nature of the hearing;

B. a statement of the legal authority and jurisdiction under which the hearing is to be held; and

C. a short and plain statement of the matters of fact and law asserted so that all have sufficient notice of the issues involved to afford them reasonable opportunity to prepare; if the issues cannot be fully stated in advance, they shall be fully stated as soon as practicable; in all cases of delayed statement, or where subsequent amendment of the issues is necessary, sufficient time shall be allowed after full statement or amendment to afford all parties reasonable opportunity to prepare.
[10.5.500.11 NMAC - N, 6-30-04]

10.5.500.12 VENUE: The hearings shall take place at the department of public safety headquarters in Santa Fe, New Mexico or at such other location in Santa Fe as the hearing officer may designate.
[10.5.500.12 NMAC - N, 6-30-04]

10.5.500.13 RECORD:

A. The record in a proceeding subject to this rule shall include:

(1) all pleadings, motions and intermediate rulings;

(2) evidence received or considered;

(3) a statement of matters officially noticed;

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

(5) proposed findings and conclusions; and

(6) any decision, opinion or report by the hearing officer conducting the hearing.

B. The hearing shall be recorded by a certified court monitor.
[10.5.500.13 NMAC - N, 6-30-04]

10.5.500.14 EVIDENCE:

A. In this proceeding the rules of evidence shall be followed.

B. Irrelevant, immaterial or unduly repetitious evidence shall be excluded. When necessary to ascertain facts not reasonable susceptible to proof under the rules of evidence, evidence thereunder may be admitted, except where precluded by statute, if it is of type commonly relied upon by reasonably prudent men in the conduct of their affairs. The hearing officer shall give effect to the rules of privilege recognized by law. Objections to evidentiary offers shall be made and noted in the record. Subject to these requirements, when a hearing will be expedited and the interests of the parties will not be prejudiced substantially, any part of the evidence may be received in written form.

C. All evidence, including any records, investigation reports and documents in the possession of the department of public safety, which it relies upon as evidence in this hearing, shall be offered and made part of the record in the proceeding.

D. The parties may call and examine witnesses, introduce exhibits, cross-examine witnesses who testify and submit rebuttal evidence.

E. The officer subject to these proceedings has the right to be represented by counsel of his choice and at his own expense. Such counsel shall be an attorney licensed to practice law in the state of New Mexico.

F. If the officer who has requested a hearing does not appear and no continuance has been granted, the hearing officer may hear the evidence of the witnesses who appear, and then may proceed to consider the matter and dispose of it on the basis of the evidence before it and in the manner required by these rules. For good cause shown, the hearing officer may continue the hearing.

G. Where relief or procedure is not otherwise provided for in these rules, the rules of civil procedure and the rules of evidence may be utilized by the parties at any stage of the proceeding, and if refused by the hearing officer, then upon application to the First Judicial District Court for the entry of an order providing for such relief or procedure.

H. Prior to each initial or tentative decision, the parties shall be allowed a reasonable opportunity to submit briefs for the consideration of the hearing officer.

I. The record shall include all briefs, proposed findings and exceptions and shall show the ruling upon each finding, exception or conclusion presented. All decisions at any stage of the proceeding become part of the record and shall include a statement of findings of fact and conclusions of law, as well as the reasons or basis therefore, upon all material issues of fact, law or discretion involved, together with the appropriate rule, order, sanction, relief or denial thereof.

[10.5.500.14 NMAC - N, 6-30-04]

10.5.500.15 DEPOSITIONS, INSPECTION OF DEPARTMENT FILES AND DISQUALIFICATIONS: The hearing officer may, subject to the rules of privilege and confidentiality recognized by law, require the furnishing of information, the attendance of witnesses and the production of books, records, papers and other objects necessary and proper for the purposes of the proceeding.

A. The parties may take depositions of witnesses, including the parties, within or without the state, in the same manner as provided by law for taking depositions under the rules of civil procedure for the district courts, and they may be used in the same manner and to the same extent as permitted in the district court.

B. The hearing officer may issue subpoenas requiring, upon reasonable notice, the attendance and testimony of witnesses and the production of any evidence, including books, records, correspondence or documents relating to any matter in question in the proceeding.

C. The form of the subpoena shall adhere, insofar as practicable, to the form used in civil actions in the district courts. Witnesses summoned, unless they are employees of the department, shall be paid the same fees for attendance and travel as in civil actions in the district courts unless otherwise provided by law. Service of subpoenas shall be in accordance with the rules of civil procedure for the district courts.

D. The parties are entitled as of right to the issue of subpoenas in the name of the commission. The parties shall present a written request to the hearing officer for the issuance of the subpoena and he shall issue the subpoenas requested. The subpoena shall show on its face the name and address of the party at whose request the subpoena was issued. The cost and fees for attendance of witnesses shall be born by the party that summoned the witness.

E. Any witness summoned may petition the hearing officer, or if the hearing officer denies the petitioner's requested relief, the first judicial district court to vacate or modify the subpoena served on the witness.

F. In the case of disobedience to any subpoena issued and served under this section or for refusal of any person to produce any thing or to testify to any matter regarding which he may be interrogated lawfully under the rules of evidence, the parties or the hearing officer may apply to the first judicial district court for an order to compel compliance with the subpoena. The district court shall hear the matter as expeditiously as possible. If the disobedience or refusal is found to be unlawful, the district court shall enter an order requiring compliance in full or as modified and order whatever relief justice may require. Disobedience of the court order shall be punished as contempt of the district court in the same manner and by the same procedure as provided for like conduct committed in the course of judicial proceedings.

G. Department files and records, including but not limited to investigation reports, statements, memoranda, correspondence, or other data pertaining to the proceeding shall be made available for inspection and copying by the parties prior to any hearing. If the department asserts that any such information contained in the department's files and records should not be made available for any reason of confidentiality or privilege recognized by law, the question shall be determined by the hearing officer, upon application by the party requesting the information and after a hearing on the matter following reasonable notice to the parties. The hearing officer's ruling, if it is one that requires disclosure, is immediately appealable to the first judicial district court which shall hear the matter as expeditiously as possible.

H. Any hearing officer or commissioner shall withdraw from any proceedings in which he cannot accord a fair and impartial hearing or consideration.

(1) Any party may request a disqualification of any hearing officer or commissioner on the grounds of the person's inability to be fair and impartial by filing an affidavit with the commission promptly upon the discovery of the alleged grounds for disqualification, stating with particularity the grounds which it is claimed that the person cannot be fair and impartial.

(2) The disqualification shall be mandatory if sufficient factual basis is set forth in the affidavit.

(3) The commission shall promptly appoint a fair and impartial replacement for the hearing officer disqualified. If a commission member is disqualified, that commissioner shall not take part in the proceedings. If the replacement hearing officer is disqualified, or in any other case not otherwise provided for, a replacement shall be appointed by a justice of the New Mexico supreme court.

[10.5.500.15 NMAC - N, 6-30-04]

10.5.500.16 EX PARTE COMMUNICATIONS: No party or representative of a party or any other person shall communicate with any commission member or counsel for the commission or hearing officer who participates in making the decision in any proceeding under this part unless a copy of the communication is sent to all parties to the proceeding.

[10.5.500.16 NMAC - N, 6-30-04]

10.5.500.17 DECISION: The hearing officer shall prepare and submit to the commission a summary of evidence taken at the hearing, proposed finding findings of fact and conclusions of law, separately stated. The sole issue to be decided by the commission conducted pursuant to these rules and Section 29-2-11C is whether, by a preponderance of the evidence, just cause exists to support the action proposed by the department.

A. If the commission finds

the action proposed by the department is supported by just cause, the commission shall adopt and enter findings of fact and conclusions of law submitted by the hearing officer in its determination and these findings of fact and conclusions of law shall form the final decision.

B. If the commission finds the action proposed by the department is without just cause, the commission shall enter findings of fact and conclusions of law to support its determination in the form of a final decision. In the event that a final decision of the commission that just cause did not exist to support the action taken by the department the commission may also make recommendations to the secretary of the department of public safety as to what, if any, discipline would be supported by the evidence. If the secretary agrees with the recommendation of the commission he may so notify them and they shall enter such findings of fact and conclusions of law to support their recommended discipline and a final order imposing the discipline.
[10.5.500.17 NMAC - N, 6-30-04]

10.5.500.18 PETITION FOR JUDICIAL REVIEW: An officer subject to discipline under this part and Section 29-2-11C may appeal the final decision to the first judicial district court pursuant to Section 39-3.1.1 NMSA 1978.
[10.5.500.18 NMAC - N, 6-30-04]

HISTORY OF 10.5.500 NMAC: [RESERVED]

NEW MEXICO DEPARTMENT OF PUBLIC SAFETY

This is an amendment to 10.5.100 NMAC, Sections 1, 5 and 8. This rule was also reformatted and renumbered from 10 NMAC 5.100 to comply with current NMAC requirements, effective June 30, 2004.

10.5.100.1 ISSUING AGENCY: Department of Public Safety, State Police Division [~~P.O. Box 1628 Santa Fe, NM 87504-1628~~]
[5-15-98; 10.5.100.1 NMAC - Rn & A, 10 NMAC 5.100.1, 6-30-04]

10.5.100.5 EFFECTIVE DATE: December 22, 1993, unless a later date is cited at the end of a section [~~or paragraph. Repromulgated in NMAC format effective May 15, 1998~~].
[12-23-93, 5-15-98; 10.5.100.5 NMAC - Rn & A, 10 NMAC 5.100.5, 6-30-04]

10.5.100.8 STANDARD OF CONDUCT: All employees are expected to adhere to the provisions of this rule and are subject to such disciplinary action for violation of any of these rules as deemed appropriate by the secretary of the department of public safety.

A. Employees shall:

(1) obey all laws of the United States, or any state and local jurisdiction in which the employees are present;

(2) obey all rules and regulations, policies, procedures, directives and lawful orders issued by supervisors; and

B. Employees shall satisfactorily perform their duties and assume the responsibilities of their positions. Unsatisfactory performance may be demonstrated by violating any one of the following provisions

(1) a lack of knowledge of the application of laws required to be enforced;

(2) an unwillingness or inability to perform assigned tasks;

(3) the failure to conform to work standards established to the employees rank, grade or position as set forth in the job specifications.

C. Employees shall conduct themselves at all times, both on and off duty, in such a manner as to reflect most favorably on the department. Conduct unbecoming an employee shall include that which brings the department into disrepute or reflects discredit upon the employee as a member of the department, or that which impairs the operation or efficiency of the department or employee. These shall include but not be limited to the following:

(1) Employees shall not consort with or, in any way, fraternize with persons of known bad character or ill repute in a manner which clearly conflicts with the duties of the employees or functions of the department unless such association is a necessary part of the employees official duties.

(2) Employees shall not feign illness or injury, falsely report themselves ill or injured, or otherwise deceive or attempt to deceive any official of the department as to the condition of their health.

(3) Employees shall carry out all proper orders given them by supervisors in the line of duty without hesitation or criticism. Employees will take up matters affecting themselves, their position and departmental business with their immediate supervisor only, or through proper channels.

(4) Employees shall promptly obey any lawful orders of any supervisor. This will include orders relayed from a supervisor by an employee of the same or lesser rank, or transmitted via the police radio, telephone, or teletype or other form of communication. The failure or refusal to obey any lawful order shall be deemed insubordination.

(5) Employees who are given an otherwise proper order which is in conflict with a previous order, rule, regulation or directive shall respectfully inform the supervisor issuing the conflicting order. If the supervisor issuing the order does not alter or retract the conflicting order, the new order shall stand. Under these circumstances, the responsibility for the conflict shall be upon the supervisor. Employees shall obey the conflicting order and shall not be held responsible for disobedience of the order, rule, regulation or directive previously issued.

(6) Employees shall not obey any order which they know or should know would require them to commit any illegal act. If in doubt as to the legality of an order, employees shall request the issuing supervisor to either clarify the order or to confer with higher authority.

(7) All employees shall be courteous to the public, supervisors and all other employees, as well as any person the employee has contact with during the performance of his/her duties and responsibilities. Employees shall be tactful in the performance of their duties, shall control their tempers, and exercise the utmost patience and discretion, and shall not engage in argumentative discussions even in the face of extreme provocation. In the performance of their duties, employees shall not use coarse, violent, profane or insolent language or gestures, and shall not express any prejudice concerning race, religion, politics, national origin, sex, lifestyle or similar characteristics. When any person requests assistance or advice, all pertinent information will be obtained in an official and courteous manner and will be properly and judiciously acted upon.

(8) Employees shall maintain a level of good moral character in their personal and business affairs, which is in keeping with the highest standards of the law enforcement profession. Employees shall not participate in any incident which impairs their ability to perform their duties or impedes the operation of the department or causes the department to be brought into disrepute.

(9) Employees will not set or accept appearance bonds regardless of any delegation of presumed authority by a magistrate or judge permitting the officer to accept appearance bonds.

D. Employees will properly care for and maintain all state equipment issued to or used by the employee.

E. An employee will not represent himself/herself as speaking on behalf of the department of public safety, in any court proceeding, civil or criminal, for purpose of being a character witness.

F. All employees are

expected to conduct themselves accordingly as specified.

G. Employees will concern themselves strictly with tasks assigned.

(1) Sleeping on duty is not permitted.

(2) Forms of entertainment which distract the employees from the performance of their duty are not allowed.

(3) Unless otherwise authorized, employees will not leave assigned locations during a tour of duty.

(4) Employees will speak the truth at all times and in cases where they would not be allowed to divulge facts, they will so state.

(5) Employees will not engage in any form of gambling while on duty except as required in the performance of duty or will not engage in any form of illegal gambling while off duty.

(6) Employees will not use chewing gum or tobacco by any method when in direct contact with the public in an official capacity.

H. Employees will be punctual in reporting for duty at the time designated by their supervisor and not be absent from duty without authorized leave.

(1) An employee shall not leave this state for official business without permission from the chief. If the out-of-state trip is in response to subpoena, a copy of the subpoena should be sent to the chief's office. If the trip was to testify and no subpoena was served, a copy of a subpoena should be brought back and forwarded to the chief's office.

(2) An employee shall not leave his/her district or station, while on duty, until notification has been given to his/her immediate supervisor. The employee shall furnish his/her supervisor with an itinerary and places where he/she can be contacted in case of emergency calls. In cases of fresh pursuit of a fugitive, it is not necessary to secure permission to leave the district or station.

I. Employees shall carry their badges and commissions on their person at all times, while on duty or while carrying a loaded concealed firearm off duty as provided by DPS policy and procedures.

(1) They shall furnish their name to any person requesting that information when they are on duty or while representing themselves in an official capacity.

(2) Exception: When the withholding of such information is necessary for the performance of police duties.

J. Employees shall submit all necessary reports and official documents on time and in accordance with established documents on time and in accordance with established departmental or other procedures. Reports and documents submitted by employees shall be truthful and complete, and no employees shall knowingly enter or cause to be entered any inaccurate, false, or improper information. All DPS law enforcement reports, records and evidence are privileged and confidential and may be released only upon written authority of the secretary, or his verbal authority, if written authority cannot reasonably be obtained except as required by court order.

K. [RESERVED]

L. All employees are expected to meet their financial obligations in a timely manner and live within their financial means. This does not preclude any employee from properly proceeding in bankruptcy.

M. Any employee wishing to secure any type of supplemental employment must secure written permission from the secretary. This supplemental employment includes any tasks performed for which the employee is compensated.

(1) Such supplemental employment will not interfere in any way with the employees primary duties and responsibilities as a department of public safety employee.

(2) When requesting permission from the secretary, the employee must specify hours expected to be worked, type of business, location and duration of employment.

(3) If permission is granted, the secretary may impose conditions on the supplemental employment.

(4) This regulation applies to all employees including those on any type of leave or suspension.

N. All employees will be physically and mentally fit at all times. The secretary may order a physical or psychological examination to assure compliance with this rule.

O. Financial gain by employees. Employees will not accept gifts, gratuities, bribes, loans or rewards which are intended to influence the employee in the performance of their duties and responsibilities or for tasks performed as part of their duties. The employee cannot retain rewards for personal use, but rather will forward the reward to the secretary's office for appropriate disposition.

P. Employees will not make any statements in any form which adversely impacts or impairs the efficient operations of the department.

Q. The following regulations are for the purpose of providing direction and guidance to all employees as concerns political activity.

(1) While off duty and out of uniform, employees shall be permitted to:

(a) express opinion as invididuals on political issues and candidates;

(b) attend political conventions, rallies, fund raising functions and similar political gatherings in an unofficial capacity;

(c) actively engage in any non-partisan political function, partisan meaning an adherent to a party, faction, cause or person; actively engaging in activities of private, fraternal and/or social organizations which do not conflict with the mission of the department of public safety and associated responsibilities is permissible;

(d) sign political petitions as individuals;

(e) make financial contributions to political organization;

(f) perform non-partisan duties as prescribed by state or local laws;

(g) hold membership in a political party and participate in its functions to the extent consistent with the law and consistent with this regulation;

(h) otherwise participate fully in public affairs, except as provided by law, to the extent that such endeavors do not impair the neutral and efficient performance of official duties, or create real or apparent conflicts of interest.

(2) Employees are prohibited at all times from:

(a) using their official capacity to influence, interfere with, or affect the results of an election;

(b) assuming active roles in management, organization or financial activities of partisan political clubs, campaigns or parties;

(c) serving as officers of partisan political parties and clubs;

(d) becoming candidates for, seeking election to, or running for, or campaigning for, a partisan elective public or political office;

(e) soliciting votes in support of, or in opposition to, any partisan candidates;

(f) serving as delegates to a political party convention;

(g) endorsing or opposing a partisan candidate for public office in a political advertisement, broadcast or campaign literature;

(h) initiating or circulating a partisan nominating petition;

(i) organizing, selling tickets to, or actively participating in a fund-raising function for a partisan political party or candidate;

(j) addressing political gatherings in support of, or in opposition to, a partisan candidate;

(k) otherwise engaging in prohibited partisan activities on the federal, state, county or municipal level.

R. Employees will not seek self-publicity through the news media or furnish information for the primary pur-

pose of personal publicity.

S. Every employee who has a financial interest which he believes, or reasonably should have known, may be affected by actions of the department shall disclose the precise nature and value of such interest. The disclosure shall me made in writing to the secretary of state before entering employment, and during the month of January every year thereafter.

T. Employees will not use their position or permit use of their position for personal or financial gain whether directly or indirectly for themselves or any other individual or group.

U. The following apply to regulate the authorized use of a firearm:

(1) to kill a critically wounded or dangerous animal, when other disposition is impractical; or

(2) to give an alarm or call for assistance for an important purpose when no other means can be used; or

(3) for practice, preferably on an approved range under the auspices of an approved rangemaster; however, should an approved rangemaster not be available, the employee may, at his discretion, still utilize the approved range for target practice;

(4) an employee shall draw or display his firearm only for a legal use or for inspection (including cleaning, oiling and storing);

(5) as authorized by department use of force and carrying of fireams policies or any other departmental policy and procedure.

V. All employees will use the utmost care and caution in handling firearms at all times in an effort to prevent the accidental discharge of their weapons or any weapons.

W. In every instance in which an employee discharges a firearm while on duty, other than provided in Paragraph (3) of Subsection U of 10.5.100.8 NMAC, whether the discharge is accidental or not, the employee will, without delay, make a written report through channels to the chief. The office of professional standards and internal affairs will be apprised of all incidents of discharged firearms other than target practice.

X. The duty issued weapon will not be used off-duty except for duty related matters.

Y. Employees will maintain a neat appearance in groom and dress.

Z. Employees will maintain their hair style so as not to interfere with the proper wearing of all standard head gear, and hair will be kept neat, clean and trim.

(1) Male employees will keep hair cut assuring that the back of the hair does not touch the shirt collar, the sides do not bulk at or extend over the ear, and front is combed to the side or back and will not protrude below the headband.

(a) Sideburns will be squared and will not extend below the lowest part of the exterior ear opening or tragus and will end with a clean shaven horizontal line.

(b) All male employees will be clean shaven. Goatees, beards or mustaches are not permitted.

(c) Exceptions are permitted if required in the performance of the employee's duty.

(2) Female employees will keep hair cut assuring that the back and sides do not touch the shirt collar and the front and back (e.g., ponytails, braids, etc.) will not protrude below the headband.

(3) Hairpieces or wigs are not permitted unless necessary to cover an uncommon baldness or to accommodate a medical condition. If worn, wig or hairpiece will be properly secured so as not to handicap the proper wearing of the headgear and must keep the standards stated in Paragraphs (1) and (2) of Subsection Z of 10.5.100.8 NMAC above.

(4) Cosmetics for female employees are permitted if in good taste using conservative natural looking cosmetics.

AA. All employees will dress in appropriate civilian clothes when appearing in court for purposes of any trial, except when appearing for trial or any proceeding in magistrate, metropolitan or municipal courts, unless permission is obtained from the chief to appear in uniform.

(1) Male employees will dress in conservative sport coat or suit with tie and will appear with shoes shined and clothes cleaned and neatly pressed.

(2) Female employees will dress in conservative pantsuit, skirt and blouse, or dress, each of which must be properly coordinated as well as clean and neatly pressed.

(3) Employees may dress in the uniform when appearing at any proceedings in magistrate, metropolitan or municipal court, subject to the reasonable approval of the employee's immediate supervisor as to whether it is appropriate to appear in uniform in a specific proceeding.

(4) For purposes of appearing at proceedings other than trial (e.g., grand jury, arraignment, hearings or motions, preliminary hearing, etc.), the employee may dress in uniform subject to the approval of the employee's immediate supervisor based on the supervisors reasonable discretion.

(5) In any case, employees will not appear in court in uniform unless need for appearance is relative to their duties and responsibilities.

BB. Military courtesy will be adhered to by employees.

CC. The hand salute will be used in the following circumstances:

(1) Employees in uniform will salute the governor of this state (or other states, where applicable), the chief of the New Mexico state police, deputy chiefs, majors, captains and lieutenants; except when the ranking officers are in civilian clothing, the salute is not required. It will be mandatory to salute these officials only the first time seen each day.

(2) As a gesture of common courtesy, uniformed employees will salute high-ranking military officers.

(3) Uniformed employees, upon approach of the national colors, will stand at attention and execute the hand salute. The time of the salute is when the colors approach within six paces of ones position, holding the salute until the colors have been carried six paces beyond. For the purpose of interpretation, the national colors will be any American flag. Flags other than the national colors will not be saluted.

(4) Uniformed employees will stand at attention and give the hand salute at the first note of the national anthem and hold the salute until the last note of the music. During formal raising and lowering of the national colors, the same procedure will be followed as in the playing of the national anthem. When the national anthem is played and national colors are not flown, uniformed employees will stand at attention, facing the music, saluting at the first note and holding the salute until the last note.

(5) General procedures for salutes are as follows:

(a) Normally, the hand salute shall be rendered only from a standing position of attention, except that a ranking employee being saluted need not rise from a seated position to return a salute.

(b) A uniformed employee, upon reporting to the chief, will remove his headdress before entering the chief's office. The employee will then assume the position of attention in front of the chief and salute. The employee will remain at attention unless otherwise ordered by the chief. If the employee is given permission to stand at ease or to be seated, the employee will, at the conclusion of the business, again salute the chief from the position of attention, and depart.

(c) The driver of a motor vehicle will not salute if the vehicle is in motion. If it is stopped, he will salute without arising from his seat. Drivers of moving vehicles will not be saluted. Passengers in moving or stationary vehicles will salute on the same occasions as when standing or walking, but they need not rise or alight from the vehicle, except as later provided in these rules.

(d) Uniformed employees in a

standing vehicle, upon the approach of the national colors, or upon the first note of the national anthem, will alight from the vehicle and salute from the position of attention. The driver of the vehicle will remain in the seat and salute.

(e) Uniformed employees in a moving vehicle, upon passing the national colors, shall salute the colors, except that the driver shall not salute.

DD. Employees in civilian clothing will adhere to the following procedures for salutes: Employees in civilian clothing will salute the national colors and the national anthem by standing at attention, if uncovered. If covered, they will stand at attention and uncover, holding the headdress over the heart with the right hand.

EE. The hand salute will not be required if it would interfere with duty, or in emergency situations.

FF. Employees will abide by the following procedures regarding the removal of headdresses:

(1) Employees will remove their headdress in churches, formal or informal gatherings when seated, when in restaurants, funeral parlors, hospital rooms, when entering courts and while in private residences.

(2) When the headdress is removed, it shall be placed underneath the left arm at the elbow, with the badge foremost. (This shall not exclude the placing of the headdress on a hat rack or other proper place.)

(3) Uniformed employees will remove their headdress and bow their heads during prayer, except officers assigned to honor guard, standing at attention or in military formation.

GG. The preceding rules for saluting and courtesy are intended to direct a correct behavior of employees under normal conditions, and will not apply in any emergency when police duty is being performed which requires the undivided attention of the employee.

HH. Supervisors will instruct employees on special assignments as to military courtesy if it is likely to be required during any occasion.

II. Displaying of the flag:

(1) The flag will be displayed at half staff in accordance with Presidential Proclamation number 3044.

(2) The flag will also be displayed at half staff when any law enforcement officer in the state of New Mexico is killed in the line of duty. The flag will fly at half staff once the department is assured of the officers death and will be returned to full staff on the day after the funeral.

(3) The flag will not be displayed during inclement weather.

JJ. Disciplinary action.

KK. The chief or secretary will have the ultimate discretion to decide on penalties subject to mitigating or aggravating circumstances.

LL. At least one copy of each official written reprimand shall be placed in the offenders headquarters personnel file, one copy to the employees supervisor, one copy to the chief and other copies as needed. Reprimands shall be dated and signed by the offender and shall not be used for purposes of [~~8.39~~] this section for more than one calendar year after being issued.

MM. Repeated violations of rules and regulations of this department, or any other course of action or conduct indicating an employee has little or no regard for the employees obligations as set forth in the employees job specifications or in these rules and regulations or any adverse and unreasonable course of conduct or action which impairs the operations or efficiency of the department may be cause for dismissal. Repeated violations must be supported by documented evidence. This shall apply regardless of the severity of the offenses, and regardless of whether these violations are of the same type.

NN. The following pertains to disciplinary proceedings: Disciplinary proceedings pertaining to members of the New Mexico state police holding a permanent commission shall be in accordance with Section 29-2-11, NMSA, 1978 and 10.5.500 NMAC.

OO. The following procedure shall be followed when a permanent employee is being considered for suspension for a period not to exceed thirty (30) days.

(1) The secretary and chief will advise the employee of [~~his~~] their determination. If the employee accepts the [~~chiefs~~] decision, the penalty will be carried out [~~by the secretary~~].

(2) Should the employee wish to appeal the [~~chiefs~~] decision, he will request such appeal, in writing to the chief, within five days of receipt of the letter of suspension.

(3) There is created for these purposes a disciplinary hearing panel (DHP) which will timely schedule a hearing on the allegations contained in the chiefs letter of suspension. The DHP will consist of a person or persons appointed by the chief.

(4) The [~~FHP~~] DHP will hear testimony regarding both sides of the issues and make its determination based on the evidence presented before it. The panel will dictate any other procedures to be followed. A record or tape recording shall be made of these proceedings. As concerns the applicability of the New Mexico Rules of Evidence to these proceedings, a lesser standard may be utilized by the DHP, although introduction of any evidence must be based on a reasonable prudent man standard, i.e. the type relied upon reasonably prudent men in the conduct of their affairs. Private counsel may not be present before the DHP. The DPS office of legal affairs may be present to advise the DHP only on questions of law.

(5) Within ten (10) days after the completion of the hearing, the DHP will make written findings of fact and conclusions of law which will then be presented to the chief. Should the DHP choose to recommend an amendment to this penalty, it may do so by stating in writing the justification for the recommendation.

(6) After the DHP report is made to the chief, the [~~chiefs recommendation will be sent to the secretary for final determination~~] chief and the secretary will impose the final discipline. No further appeal shall be allowed.

[~~**(7)** After the final action of the secretary pursuant to Section 29-2-11 NMSA 1978, the DPS advisory commission may review the final action at its next regularly scheduled meeting or as soon as possible thereafter if so requested in writing by the employee within 5 days of his receipt of the action. The review shall consist of a review of the findings in fact and conclusion of law and any other part of the record the commission may desire. Subsequent to the review, the commission, in its discretion, may reverse, amend or otherwise alter the penalty. No further appeal shall be allowed.~~]

PP. [~~In the event the officer is to be removed from office, demoted or suspended for a period of more than thirty days, specific written charges shall be filed with the department of public safety advisory commission as provided in Section 29-2-11 NMSA 1978. Timely and adequate notice of the charges to the person charged shall be provided and a prompt hearing shall be held by the commission. The hearing shall be a matter of record and rules of procedure governing the hearing and the content of the record if any, shall be promulgated by the commission. The person so charged has the right to be represented by counsel of his own choice and at his own expense at the hearings. A complete record of the hearing shall be made and, upon request, a copy of it shall be furnished to the person charged. The person may require that the hearing be public.~~

~~**(1)** In the event the commission finds the person charged shall be removed, demoted or suspended in excess of thirty days, the person may appeal to the district court of Santa Fe county as provided in Section 29-2-11 NMSA 1978. The commission shall serve its findings and conclusions on the secretary for execution, as provided in Section 9-19-11 NMSA 1978.~~

~~(2) The commission, at its discretion, may retain to assist them, independent counsel licensed to practice in the state of New Mexico which may include but is not necessarily limited to assistant attorneys general. The secretary shall be represented in these proceedings pursuant to this Section by the attorneys of the department of public safety office of legal affairs, unless a conflict becomes apparent, at which time, other counsel may be retained to represent the secretary.~~] [RESERVED]

QQ. Pursuant to Section 29-2-9 NMSA 1978, all New Mexico state police officers on a probationary status may be removed or suspended at the discretion of the chief. The employee, within five days of receipt of notice of intended action by the chief to remove or suspend may request, in writing, an opportunity to be heard by the chief.

[5-15-98; 10.5.100.8 NMAC - Rn & A, 10 NMAC 5.100.8, 6-30-04]

NEW MEXICO REGULATION AND LICENSING DEPARTMENT

FINANCIAL INSTITUTIONS DIVISION

TITLE 12 TRADE, COMMERCE AND BANKING
CHAPTER 15 FINANCIAL INSTITUTIONS - GENERAL
PART 5 HOME LOAN PROTECTION ACT - FLIPPING

12.15.5.1 ISSUING AGENCY: Financial Institutions Division of the Regulation and Licensing Department.
[12.15.5.1 NMAC - N, 06/30/2004]

12.15.5.2 SCOPE: All creditors subject to the Home Loan Protection Act, Sections 58-21A-1 to -14 NMSA 1978 (2003, as amended through 2004) ("Act").
[12.15.5.2 NMAC - N, 06/30/2004]

12.15.5.3 STATUTORY AUTHORITY: Section 58-21A-13 NMSA 1978.
[12.15.5.3 NMAC - N, 06/30/2004]

12.15.5.4 DURATION: Permanent.
[12.15.5.4 NMAC - N, 06/30/2004]

12.15.5.5 EFFECTIVE DATE: June 30, 2004, unless a later date is cited at the end of a section.
[12.15.5.5 NMAC - N, 06/30/2004]

12.15.5.6 OBJECTIVE: The objective of this rule is to provide guidance to creditors covered by the act regarding the application of Section 58-21A-4(B) NMSA 1978, which prohibits creditors from engaging in the unfair act or practice of flipping a home loan.
[12.15.5.6 NMAC - N, 06/30/2004]

12.15.5.7 DEFINITIONS: For purposes of this rule, the definitions set forth in the act and regulations adopted pursuant to the act shall apply unless otherwise noted.
[12.15.5.7 NMAC - N, 06/30/2004]

12.15.5.8 KNOWINGLY AND INTENTIONALLY ENGAGING IN THE ACT OR PRACTICE OF FLIPPING: For purposes of Section 58-21A-4(B) NMSA 1978, a creditor shall not have "knowingly and intentionally" engaged in the unfair act or practice of flipping a home loan when the new loan provides a "reasonable, tangible net benefit" to the borrower. A creditor shall have "knowingly and intentionally" engaged in the unfair act or practice of flipping a home loan when the new loan does not provide a "reasonable, tangible net benefit" to the borrower and the creditor made the new loan with the intent and knowledge that the new loan did not provide a reasonable, tangible net benefit to the borrower.
[12.15.5.8 NMAC - N, 06/30/2004]

12.15.5.9 REASONABLE, TANGIBLE NET BENEFIT TO THE BORROWER:

A. The reasonable, tangible net benefit" standard in Section 58-21A-4 B NMSA 1978, is inherently dependent upon the totality of facts and circumstances relating to a specific transaction. While the refinancing of certain home loans may clearly provide a reasonable, tangible net benefit, others may require closer scrutiny to determine whether a particular loan provides the requisite benefit to a borrower.

B. Because of the fact-specific nature of the "reasonable, tangible net benefit" inquiry, lenders are not expected to create a single one-size-fits-all test to use for every loan application. While the majority of loans may be evaluated using an appropriate economic analysis of the old and new loan, each lender should develop and maintain policies and procedures for evaluating loans in circumstances where an economic test, standing alone, may not be sufficient to determine that the transaction provides the requisite benefit.

C. In evaluating whether lenders are in compliance with the flipping provision, the financial institutions division will focus on whether a lender has policies and procedures in place and that were used to determine that borrowers received a reasonable, tangible net benefit in connection with the refinancing of loans. For example, lenders may wish to create procedures for additional upper-level management review in cases where the benefit to the customer is not clear based on a simple calculation of savings. Lenders may also wish to devise worksheets for collecting relevant information from the borrower such as the borrower's financial status, objectives for use of the funds and knowledge of other alternatives.

D. Examples of factors that could be relevant include, but are not limited to, the following:

(1) Terms of the new and old loan, including, but not limited to, note rate, amortization schedule, and balloon payment provisions, provided that costs associated with (and paid at or before closing of) the old loan, such as closing costs or points and fees other than prepayment penalties, are not normally relevant to the determination of flipping;

(2) Costs of the new loan, including points and fees charged on the new loan as well as other closing costs associated with the transaction as routinely disclosed on the closing statement;

(a) loan-to-value ratio of the new loan compared to that associated with the outstanding balance on the existing loan;

(b) debt-to-income ratio of the borrower before and after the transaction;

(c) amount of time that has lapsed between the new loan and the origination of the old loan or previous refinancing; and

(d) in cases where economic benefits do not demonstrably indicate that a reasonable, tangible net benefit has occurred, a significant reason that explains the need for, and proposed use of, the loan proceeds.

E. Lenders may use other management controls to assess whether a loan transaction provides the requisite benefit.

F. While the financial institutions division will not mandate that lenders use a prescribed form or system for evaluating the economic or non-economic benefits of a particular home loan, lenders are encouraged to maintain records in the loan file to demonstrate that they performed an analysis of the reasonable, tangible net benefit standard in each refinancing transaction.

G. Borrowers are responsible for the disclosure of information provided on the application for a home loan. Truthful disclosure of all relevant facts and financial information concerning the borrower's circumstances is required in order for lenders to evaluate and determine that the refinance loan transaction provides a reasonable, tangible net benefit to the borrower. Lenders cannot, however, disregard

known facts and circumstances that may place in question the accuracy of information contained in the application.

H. An appropriate analysis reflected in the loan documentation can be helpful in determining that a lender satisfies the statutory requirement. As part of a lender's analysis, a lender may wish to obtain and document an explanation from the borrower regarding any non-economic benefits the borrower associates with the loan transaction. It should be noted, however, that because it is incumbent on the lender to conduct an analysis of whether the borrower received a reasonable, tangible net benefit, a borrower certification, standing alone, would not necessarily be determinative of whether a loan provided that benefit.
[12.15.5.9 NMAC - N, 06/30/2004]

HISTORY OF 12.15.5 NMAC: [RESERVED]

NEW MEXICO REGULATION AND LICENSING DEPARTMENT
FINANCIAL INSTITUTIONS DIVISION

TITLE 12 TRADE, COMMERCE AND BANKING
CHAPTER 15 FINANCIAL INSTITUTIONS - GENERAL
PART 6 HOME LOAN PROTECTION ACT - REASONABLE DUE DILIGENCE STANDARD FOR DETERMINING HIGH-COST HOME LOANS

12.15.6.1 ISSUING AGENCY: Financial Institutions Division of the Regulation and Licensing Department.
[12.15.6.1 NMAC - N, 06/30/2004]

12.15.6.2 SCOPE: Any person or his agent who purchases or is otherwise assigned a high-cost home loan subject to the Home Loan Protection Act, Sections 58-21A-1 to -14 NMSA 1978 (2003, as amended through 2004) ("Act").
[12.15.6.2 NMAC - N, 06/30/2004]

12.15.6.3 STATUTORY AUTHORITY: Section 58-21A-13 NMSA 1978.
[12.15.6.3 NMAC - N, 06/30/2004]

12.15.6.4 DURATION: Permanent.
[12.15.6.4 NMAC - N, 06/30/2004]

12.15.6.5 EFFECTIVE DATE: June 30, 2004, unless a later date is cited at the end of a section.
[12.15.6.5 NMAC - N, 06/30/2004]

12.15.6.6 OBJECTIVE: The objective of this rule is to generally describe the type of circumstances the financial institutions division will consider in determining whether the reasonable due diligence standard set forth in Section 58-21A-11 of the act is satisfied.
[12.15.6.6 NMAC - N, 06/30/2004]

12.15.6.7 DEFINITIONS: For purposes of this rule, the definitions set forth in the act and regulations adopted pursuant to the act shall apply unless otherwise noted.
[12.15.6.7 NMAC - N, 06/30/2004]

12.15.6.8 REASONABLE DUE DILIGENCE:

A. Section 58-21A-11 of the act provides that a person who purchases or is otherwise assigned a high-cost home loan is not subject to an action for certain claims and defenses if the person can demonstrate by a preponderance of the evidence that a reasonable person exercising reasonable due diligence could not determine that the mortgage in question was a high-cost home loan. Due diligence means that degree of review that reasonably may be expected from a purchaser or assignee given the circumstances surrounding the transaction or the conditions existing at the time the review is exercised, including, consideration of the purchaser's or assignee's involvement with, or the proximity in time to the loan' origination.

B. In each case what constitutes reasonable due diligence by a person who purchases or is otherwise assigned a high-cost home loan is dependent on the totality of the facts and circumstances surrounding that person's loan review, policies and practices. The purpose of this rule is to make clear that in the vast majority of cases, reasonable due diligence does not require a loan-by-loan individualized review. Because the vast majority of home loans purchased or assigned in New Mexico are transacted in secondary markets through large loan pools or mortgage backed securities, the due diligence conducted need only be reasonable, not perfect.

C. Purchasers and assignees should have in effect and utilize reasonable compliance policies and conduct quality control review of appropriate loan documentation, whether by sampling methods or otherwise, to identify and avoid the purchase or acceptance of high-cost home loans.

(1) If none of the loans reviewed is a high-cost home loan, and if all of the other requirements of Subsection A of Section 11 are met, then there shall be a rebuttable presumption that a purchaser or assignee has exercised reasonable due diligence.

(2) When a reasonable review discloses one or more high-cost home loans, then an upgraded compliance review shall be required. The level of an upgraded compliance review may depend upon a number of factors, such as prior experience with the seller or assignor, the number of high-cost home loans identified during the initial review and the procedures used to identify and exclude high-cost home loans from submission for purchase or assignment. For example, where, after initial review, one or more high-cost home loans are uncovered in a large loan pool, there should be a more extensive review of the loan pool to evaluate: (1) a reasonable number of the remaining loans, (2) the reliability of any representations and warranties in place that there are no high-cost home loans in the pool; and (3) the extent to which there are other high cost home loans in the pool. The level of this review depends upon a number of factors, including the overall size of the pool, the reliability of the loan source, the number of high-cost home loans identified during the initial due diligence process, how extensive that initial review process was, and the procedures in place by originators to identify high-cost home loans and exclude them from the loan pool.
[12.15.6.8 NMAC - N, 06/30/2004]

HISTORY OF 12.15.6 NMAC: [RESERVED]

NEW MEXICO REGULATION AND LICENSING DEPARTMENT
FINANCIAL INSTITUTIONS DIVISION

TITLE 12 TRADE, COMMERCE AND BANKING
CHAPTER 15 FINANCIAL INSTITUTIONS - GENERAL
PART 7 HOME LOAN PROTECTION ACT - LIABILITY EXPOSURE OF CREDITORS AND ASSIGNEES

12.15.7.1 ISSUING AGENCY: Financial Institutions Division of the Regulation and Licensing Department.
[12.15.7.1 NMAC - N, 06/30/2004]

12.15.7.2 SCOPE: All creditors and assignees subject to the Home Loan Protection Act, Sections 58-21A-1 to -14 NMSA 1978 (2003 as amended through 2004) ("Act").
[12.15.7.2 NMAC - N, 06/30/2004]

12.15.7.3 STATUTORY

AUTHORITY: Section 58-21A-13 NMSA 1978.
[12.15.7.3 NMAC - N, 06/30/2004]

12.15.7.4 DURATION: Permanent.
[12.15.7.4 NMAC - N, 06/30/2004]

12.15.7.5 EFFECTIVE DATE: June 30, 2004, unless a later date is cited at the end of a section.
[12.15.7.5 NMAC - N, 06/30/2004]

12.15.7.6 OBJECTIVE: The objective of this rule is to clarify the legal liability exposure of creditors and assignees for actions that may be brought for violations of the act.
[12.15.7.6 NMAC - N, 06/30/2004]

12.15.7.7 DEFINITIONS: For purposes of this rule, the definitions set forth in the act and regulations adopted pursuant to the act shall apply unless otherwise noted.
[12.15.7.7 NMAC - N, 06/30/2004]

12.15.7.8 LEGAL LIABILITY EXPOSURE OF CREDITORS AND ASSIGNEES:

A. The purpose of this rule is to clarify the inter-relationship of Sections 58-21A-9, 58-21A-11 and 58-21A-12 of the act and the various levels of exposure to legal liability and damages that may apply for violations of the act.

B. The legal liability of creditors, and assignees is set forth, variously, in Sections 58-21A-9, 58-21A-11 and 58-21A-12 of the act.

C. Subject to certain provisions regarding timely restitution and adjustments by a creditor, Section 58-21A-9 NMSA 1978 generally authorizes a borrower to bring a civil action for violations of the act. This section authorizes actual damages, specified statutory damages, punitive damages, costs and reasonable attorney fees, as well as injunctive, declaratory and other relief. The civil action authorized in Section 58-21A-9 NMSA 1978 is non-exclusive; it will lie in addition to any other action or remedy available to a borrower under applicable law. Punitive damages are recoverable under Section 58-21A-9 NMSA 1978 only if it is proven that the violation in question was malicious or reckless. In the sense that malicious and reckless, interpreted broadly, suggest the absence of either a good faith reason or of an innocent mistake, it follows that any person who, in good faith, exercises reasonable due diligence when seeking to comply with the act will not be liable for punitive damages under Section 58-21A-9 NMSA 1978.

D. Section 58-21A-11 NMSA 1978 limits the liability of a purchaser or assignee of a high-cost home loan where the purchaser or assignee demonstrates by a preponderance of the evidence that a reasonable person exercising reasonable due diligence could not determine that the mortgage was a high-cost home loan. Section 58-21A-11 NMSA 1978 also specifies circumstances under which a purchaser or assignee shall be deemed to have exercised due diligence. The circumstances listed in Section 58-21A-11 NMSA 1978 are not intended as exclusive proof of due diligence.

E. Section 58-21A-11 NMSA 1978 also provides the limiting time periods during which there may be individual actions brought against a creditor or any subsequent holder or assignee for certain violations of the act. Section 58-21A-11 NMSA 1978 further specifies that in an individual action that is authorized under this section the borrower may recover only the amounts necessary to reduce or extinguish the borrower's liability under the loan plus costs and reasonable attorney fees. An action, claim or counterclaim under Subsection B of Section 58-21A-11 NMSA 1978 may be brought only in the borrower's individual capacity and not as a class action lawsuit. Subsection C of Section 58-21A-11 NMSA 1978 precludes a borrower from recovering punitive damages in an action brought under Subsection B of this section.

F. Section 58-21A-12 NMSA 1978 specifies that a violation of this act also constitutes an unfair or deceptive trade practice under the Unfair Practices Act (Sections 57-12-1 et seq. NMSA 1978) The maximum exposure for damages under the Unfair Practices Act is:

(1) actual damages or the sum of $100, whichever is greater; and

(2) where the practice was willfully engaged in, the court may award up to three times actual damages or $300, whichever is greater; plus

(3) reasonable attorneys' fees and costs. See Section 57-12-10 NMSA 1978.

G. The trebling of damages under the Unfair Practices Act is permissible only when a "willful" violation of the act is proven. Willful conduct is generally interpreted as the intentional doing of an act with knowledge that harm may result. It follows, therefore, that any person who, in good faith, exercises reasonable due diligence when seeking to comply with the act will not be liable for treble damages or unspecified punitive damages under the Unfair Practices Act.

H. In any class action that is authorized under the Unfair Practices Act, the class members may only recover any actual damages that were suffered, while the named plaintiffs in the action may recover in addition up to three times the actual damages as specified above. See Subsections B and E of Section 57-12-10 NMSA 1978. Willful violations of the law may expose a person to a civil penalty of not more than $5,000 for each violation.

I. While the Home Loan Protection Act allows a borrower to assert multiple types of claims, the borrower may not recover damages for the same injury or loss under Section 58-21A-11 NMSA 1978 and another cause of action. While multiple claims may be asserted in the same cause of action, only one recovery for the same injury or loss may be awarded.
[12.15.7.8 NMAC - N, 06/30/2004]

HISTORY OF 12.15.7 NMAC:
[RESERVED]

NEW MEXICO REGULATION AND LICENSING DEPARTMENT

FINANCIAL INSTITUTIONS DIVISION

TITLE 12 TRADE, COMMERCE AND BANKING
CHAPTER 15 FINANCIAL INSTITUTIONS - GENERAL
PART 8 HOME LOAN PROTECTION ACT - APPROVED THIRD-PARTY, NONPROFIT COUNSELORS

12.15.8.1 ISSUING AGENCY: Financial Institutions Division of the Regulation and Licensing Department.
[12.15.8.1 NMAC - N, 06/30/2004]

12.15.8.2 SCOPE: All creditors subject to the Home Loan Protection Act, Sections 58-21A-1 to -14 NMSA 1978 (2003 as amended through 2004) ("Act").
[12.15.8.2 NMAC - N, 06/30/2004]

12.15.8.3 STATUTORY AUTHORITY: Section 58-21A-13 NMSA 1978.
[12.15.8.3 NMAC - N, 06/30/2004]

12.15.8.4 DURATION: Permanent.
[12.15.8.4 NMAC - N, 06/30/2004]

12.15.8.5 EFFECTIVE DATE: June 30, 2004, unless a later date is cited at the end of a section.
[12.15.8.5 NMAC - N, 06/30/2004]

12.15.8.6 OBJECTIVE: The objective of this part is to establish approved third-party, nonprofit counselors required by Section 58-21A-5G NMSA 1978.
[12.15.8.6 NMAC - N, 06/30/2004]

12.15.8.7 DEFINITIONS: For purposes of this rule, the definitions set forth in the act and regulations adopted pursuant to the act shall apply unless otherwise noted.
[12.15.8.7 NMAC - N, 06/30/2004]

12.15.8.8 APPROVED THIRD-PARTY, NONPROFIT COUNSELORS: Pursuant to Subsection G of Section 58-21A-5 NMSA 1978, after April 1, 2004, no creditor shall make a high-cost home loan without first receiving certification from a third-party, nonprofit counselor approved by the United States department of housing and urban development, the New Mexico mortgage finance authority or the director of the financial institutions division of the regulation and licensing department that the borrower has received counseling on the advisability of the loan transaction. For purposes of the certification required by Subsection G of Section 58-21A-5 NMSA 1978, the financial institutions division approves any third-party, nonprofit counselor approved by the New Mexico mortgage finance authority or the secretary of the United States department of housing and urban development.
[12.15.8.8 NMAC - N, 06/30/2004]

HISTORY OF 12.15.8 NMAC: [RESERVED]

End of Adopted Rules Section

SUBMITTAL DEADLINES AND PUBLICATION DATES

2004

Volume XV	Submittal Deadline	Publication Date
Issue Number 1	January 2	January 15
Issue Number 2	January 16	January 30
Issue Number 3	February 2	February 13
Issue Number 4	February 16	February 27
Issue Number 5	March 1	March 15
Issue Number 6	March 16	March 31
Issue Number 7	April 1	April 15
Issue Number 8	April 16	April 30
Issue Number 9	May 3	May 14
Issue Number 10	May 17	May 28
Issue Number 11	June 1	June 15
Issue Number 12	June 16	June 30
Issue Number 13	July 1	July 15
Issue Number 14	July 16	July 30
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Issue Number 19	October 1	October 14
Issue Number 20	October 15	October 29
Issue Number 21	November 1	November 15
Issue Number 22	November 16	November 30
Issue Number 23	December 1	December 14
Issue Number 24	December 15	December 30

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