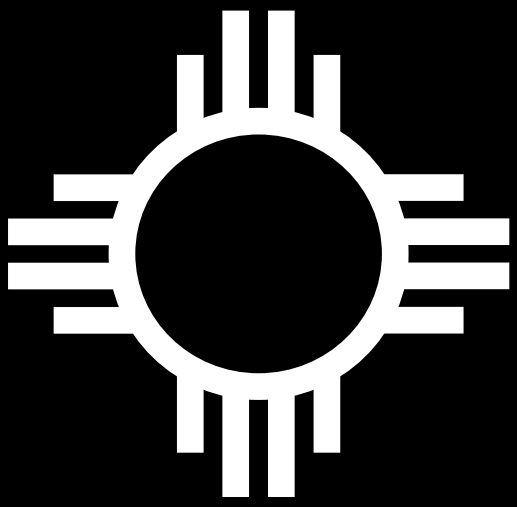
NEW MEXICO REGISTER



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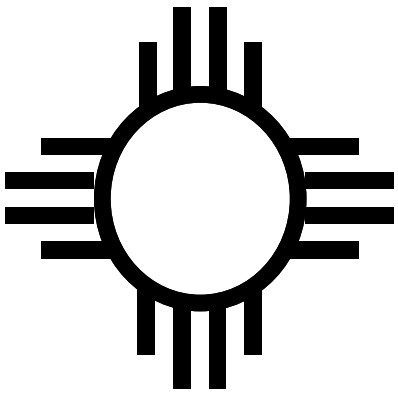

The official publication for all notices of rulemaking and filings of adopted, proposed and emergency rules in New Mexico

The Commission of Public Records
Administrative Law Division
Santa Fe, New Mexico
2007

New Mexico Register

Volume XVIII, Number 8
April 30, 2007

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Adopted Rules

Effective Date and Validity of Rule Filings

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

A=*Amended*, E=*Emergency*, N=*New*, R=*Repealed*, Rn=*Renumbered*

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Notices of Rulemaking and Proposed Rules

NEW MEXICO BOARD OF BARBERS AND COSMETOLOGISTS

Legal Notice

Notice is hereby given that the New Mexico Board of Barbers & Cosmetologists will convene a Rule Hearing to amend:
Title 16, Chapter 34, Part 1 Barbers and Cosmetologists, General Provisions
Title 16, Chapter 34, Part 2 Barbers and Cosmetologists, Licensing
Title 16, Chapter 34, Part 3 Barbers and Cosmetologists, Examinations
Title 16, Chapter 34, Part 4 Barbers and Cosmetologists, Special Licenses
Title 16, Chapter 34, Part 5 Barbers and Cosmetologists, Regular Licenses
Title 16, Chapter 34, Part 6 Barbers and Cosmetologists, Licensing By Reciprocity: Credit For Out Of State Training
Title 16, Chapter 34, Part 7 Barbers and Cosmetologists, Establishments and Enterprises
Title 16, Chapter 34, Part 8 Barbers and Cosmetologists, Schools
Title 16, Chapter 34, Part 9 Barbers and Cosmetologists, Continuing Education
Title 16, Chapter 34, Part 11 Barbers and Cosmetologists, Violations
Title 16, Chapter 34, Part 13 Barbers and Cosmetologists, Administrative Procedures
Title 16, Chapter 34, Part 14 Barbers and Cosmetologists, Fees

This Hearing will be held at the State Bar of New Mexico, 5121 Masthead NE, Albuquerque, NM, on June 11, 2007 at 8:00 a.m.

Following the Rule Hearing the New Mexico Board of Barbers and Cosmetologists will convene a regular meeting. In addition to the open meeting, the Board may go into Executive Session to consider issuance, suspension, renewal, or revocation of licenses.

Copies of the proposed rules are available on request from the Board office, P. O. Box 25101, Santa Fe, New Mexico, 87504, or phone (505) 476-4690.

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 May 28, 2007 to allow time for distribution to the Board members. Individuals planning on testifying at the hearing must provide copies of their testimony also by May 28, 2007.

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) 476-4690, no later than May 14, 2007.

NEW MEXICO CHILDREN, YOUTH AND FAMILIES DEPARTMENT
FAMILY SERVICES DIVISION

NOTICE OF PUBLIC HEARING

The Children, Youth and Families Department, Family Services, Child Care Services Bureau will hold a formal public hearing on Wednesday, May 30, 2007, from 1:00 p.m. to 3:00 p.m. in Apodaca Hall on the 2nd floor of the PERA Building located at 1120 Paseo de Peralta, Santa Fe, New Mexico to receive public comments regarding proposed changes to regulations 8.17.2 NMAC Requirements Governing Registration of Non-Licensed Family Child Care Homes.

The proposed regulation changes may be obtained at www.newmexicokids.org or by contacting Adrian Martinez at 505-827-7499. Interested persons may testify at the hearing or submit written comments no later than 5:00 p.m. on May 30, 2007. Written comments will be given the same consideration as oral testimony given at the hearing. Written comments should be addressed to: Adrian Martinez, Child Care Services Bureau, Children, Youth and Families Department, P.O. Drawer 5160, Santa Fe, New Mexico 87502-5160, Fax Number: 505-827-7361.

If you are a person with a disability and you require this information in an alternative format or require special accommodations to participate in the public hearing, please contact the Child Care Services Bureau at 505-827-7499. CCSB requests at least 10 days advance notice to provide requested alternative formats and special accommodations.

NEW MEXICO GENERAL SERVICES DEPARTMENT
RISK MANAGEMENT DIVISION

NOTICE OF PUBLIC HEARING

The Risk Management Division of the New Mexico General Services Department will hold a public hearing on an amendment to Subsection C of Section 13.10.20.8 NMAC ("Administration") and Subsection B of Section 13.10.20.10 NMAC ("General Eligibility Criteria"), which are subsections of rule 13.10.20 NMAC ("Small Employer Health Care Coverage"). The Hearing will be held at 10:00 a.m. on Thursday, May 31, 2007, at 1100 South Saint Francis Drive, Santa Fe, New Mexico in the Risk Management Division First Floor Conference Room, Suite 1004 in the Joseph Montoya Building.

The public hearing will be conducted to receive the presentation of views from interested persons with respect to the proposed amendment to Subsection C of Section 13.10.20.8 concerning the Administration of the small employer health care coverage program and to Subsection B of Section 13.10.20.10 concerning General Eligibility Criteria for the Small Employer Health Care Coverage program that has been established pursuant to state statutory law, NMSA 1978, section 10-7B-6.1.

Copies of the proposed amendment can be obtained from:

Electronic Copy
An electronic version of the proposed rule amendment also be obtained from the website for the New Mexico General Services Department Risk Management Division at: "http://www.state.nm.us/gsd/rmd/".

Printed Copy
David Dayog Black, Attorney
GSD Risk Management Division
Joseph Montoya Building
1100 South Saint Francis Drive, First Floor, Room 1004, Santa Fe, New Mexico 87505-4147
Mailing Address:
P.O. Drawer 26110, Santa Fe, New Mexico 87502-0110
(505) 827-0537 Fax (505) 827-0593
Email: david.black@state.nm.us

Written public comments regarding the proposed action must be submitted to the attention of David Dayog Black at the above "Printed Copy" physical or mailing address, fax number, or email address. Written public comments must be received on or before

5:00 p.m. on the date of the public hearing, May 31, 2007.

If you are a person with a disability who is in need of special assistance or a reasonable accommodation to attend or participate in the public hearing, please contact Paralegal Olga Lujan at the Legal Bureau of the General Services Department's Risk Management Division at (505) 827-0551 / fax (505) 827-0593. The General Services Department requests at least ten (10) days advance notice to provide requested special accommodations.

NEW MEXICO PUBLIC EDUCATION DEPARTMENT

NEW MEXICO PUBLIC EDUCATION DEPARTMENT

The Public Education Department ("Department") hereby gives notice that the Department will conduct a public hearing at Mabry Hall, Jerry Apodaca Education Building, 300 Don Gaspar, Santa Fe, New Mexico, 87501-2786, on **Wednesday,** June 6, 2007 from 9:00 A.M. until 11:00 A.M. The purpose of the public hearing will be to obtain input on the following rule:

Rule Number	Rule Name	Proposed Action
6.80.4 NMAC	CHARTER SCHOOL APPLICATION AND APPEAL REQUIREMENTS	Repeal and Replace current rule to implement changes in the 1999 Charter Schools Act (Sections 22 -8B-1, et.seq.)

Interested individuals may testify at the public hearing or submit written comments to Charter Schools Division, Public Education Department, 5600 Eagle Rock Ave. N.E., Albuquerque, N.M., 87113, Tel.: (505) 222-4762; Fax: (505) 222-4756 (don.duran@state.nm.us) Written comments must be received no later than 5 p.m. on June 6, 2007. However, the submission of written comments as soon as possible is encouraged.

Copies of the proposed rules may be accessed on the Department's website (http://ped.state.nm.us/) or obtained from Michael C de Baca, Administrative Assistant, Charter Schools Division, Public Education Department, 5600 Eagle Rock Ave. N.E., Albuquerque, N.M., 87113, Tel.: (505) 222-4762 michael.cdebaca@state.nm.us. The proposed rule will be made available at least thirty days prior to the hearings.

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 are asked to contact Mr. C de Baca, as soon as possible. The Department requests at least ten (10) days advance notice to provide requested special accommodations.

End of Notices and Proposed Rules Section

Adopted Rules

NEW MEXICO OFFICE OF THE STATE AUDITOR

This is an amendment to 2.2.2 NMAC, Appendix F, effective April 30, 2007.

Appendix F

Contract No._____

STATE OF NEW MEXICO
AUDIT CONTRACT ADDENDUM
FOR SUBCONTRACTOR

Pursuant to Subsection G of 2.2.2.8 NMAC *Requirements for Contracting and Conducting Audits of Agencies* the Contractor hereby enters into an agreement with _____, hereinafter referred to as the Subcontractor, to subcontract a portion of the services to be performed under this audit contract.

The subcontractor shall perform the following portion(s) of the contracted audit services:

_____
_____
_____.

Responsibility for the audit will

_____ Remain with the Contractor; or
_____ Be shared between the Contractor and Subcontractor.

The audit report will be signed by

_____ The Contractor; or
_____ The Contractor and the Subcontractor.

The method used to pay the subcontractor will be

_____
_____
_____.

SUBCONTRACTOR	CONTRACTOR
_____	_____
(Name)	(Name)
BY:_____	BY:_____
TITLE:_____	TITLE:_____
DATE:_____	DATE:_____

AGENCY	STATE AUDITOR
_____	
(Name)	BY:_____
BY:_____	HECTOR H. BALDERAS
TITLE:_____	
DATE:_____	DATE:_____

[2.2.2 NMAC, Appendix F - Rp, 2.2.2 NMAC Appendix F, 4-30-07]

NEW MEXICO DEPARTMENT OF GAME AND FISH

This is an amendment to 19.31.4 NMAC, Sections 9, 11, 16, effective May 1, 2007.

19.31.4.9 SEASON DATES:

A. General seasons: All trout and warm waters in New Mexico shall be open for the taking of game fish from April 1 through March 31 of the effective years, with the following exceptions:

(1) Special waters

(a) The following waters shall be open between 12 noon March 1 through 12 noon October 31: McAllister lake, upper and lower Charette lakes, Maxwell lakes 13 and 14, and Clayton lake.

(b) All waters in the Valle Vidal (Vermejo tract of the Carson national forest) shall be open from July 1 through December 31.

(c) Bonito lake shall be open from April 1 through November 30.

(d) Santa Cruz lake shall be open from April 1 through October 31.

(e) Burns canyon lake at Parkview trout hatchery shall be open from May 1 through October 31.

(f) Red River city ponds shall be open from March 1 through November 15.

(g) Black canyon creek in Grant county upstream form lower Black canyon campground shall be open from July 1 through September 30.

(2) Waters on national wildlife refuges waters on U. S. national wildlife refuges shall be open for the taking of game fish in accordance with regulations of the U. S. fish and wildlife service; provided that season dates shall be from April 1 through March 31, on those national refuges for which the fish and wildlife service has not regulated season dates.

B. Special Kokanee salmon seasons, dates, and location

(1) The following waters shall be open October 1 through December 31 for the special kokanee salmon season: Abiquiu reservoir, Chama river from El Vado lake upstream to the west boundary of the Rio Chama wildlife and fishing area, Eagle Nest lake, El Vado lake, and Navajo lake.

(2) Heron lake and the Pine river shall be open for the special Kokanee salmon season from the second Friday in November through December 31.

(3) Heron lake, including the Willow creek tributary, and the Pine river shall be closed to Kokanee salmon fishing between October 1 and the second Thursday of November.

[19.31.4.9 NMAC - Rp 19.31.4.9 NMAC, 4-15-02; A, 10-31-02; A/E, 3-31-06; A, 5-1-07]

19.31.4.11 DAILY BAG, [~~AND~~] POSSESSION LIMITS AND REQUIREMENTS OR CONDITIONS:

A. Trout

(1) Waters with reduced bag limit: No person shall fish waters regulated for reduced limits while having in excess of that limit in possession.

(2) Brown, rainbow, cutthroat, lake, Brook trout and Kokanee salmon:

(a) The daily bag limit shall be 5 trout and no more than 10 trout shall be in possession.

(b) The daily bag limit for cutthroat trout shall be 2 trout and no more than 2 cutthroat trout may in possession. Cutthroat trout are included in the bag and possession limits for trout explained in 19.31.4.11(A. 2.a) NMAC (above).

(c) The daily bag limit for lake trout shall be 2 trout and no more than 4 lake trout shall be in possession.

(3) Special Kokanee salmon season: During the special Kokanee salmon season, the daily bag limit shall be 12 Kokanee salmon in addition to the daily bag limit for trout, and no more than 24 Kokanee salmon may be possessed in addition to the possession limit for trout. It shall be unlawful to possess Kokanee salmon at Heron lake and Pine river during the closed Kokanee salmon season (October 1 through the second Thursday of November).

(4) Special trout waters - On certain waters, hereafter referred to as "Special Trout Waters", the following exceptions shall apply:

(a) On those sections of the following waters the daily bag limit shall be 2 trout and no more than 2 trout shall be in possession. Anglers must stop fishing in those waters when the daily bag limit is reached: In Rio Arriba county: all waters lying within or adjacent to the Little Chama valley ranch (Edward Sargent wildlife area) including the Rio Chamito, Sexton creek, and Rio Chama, excluding Nabor creek and Nabor lake; In Colfax county; the Shuree lakes on the Valle Vidal; In Taos county: a posted portion of the Rio Pueblo between the bridge at mile marker 55 on state hwy. 518 upstream approximately 1 mile to the Canon Tio Maes trailhead; In San Miguel county: an approximately 1-1/2 mile posted portion of the Pecos river beginning approximately 1/2 mile above the confluence of the Mora river (Mora-Pecos) upstream to approximately 1/4 mile above the bridge crossing at Cowles; In Rio Arriba county: a posted portion of the Chama river approximately 2.9 miles within the boundaries of the Rio Chama wildlife and fishing area; In Catron county: a posted portion of Gilita creek from the Gila wilderness boundary downstream approximately 5 miles to its confluence with Snow creek; In Rio Arriba county: a posted portion of the Rio de los Pinos from USFS Boundary 24 at the junction of forest road 284 and 87A, 2.5 miles upstream to the private property boundary; In Taos county: a posted portion of Red River from the confluence of Goose creek 1 mile upstream. In Catron county: Iron creek in the Gila wilderness upstream of the constructed waterfall barrier located in T12SR17WSec16NE. Every person angling for fish on this portion of Iron creek must be in possession of a Gila trout permit, issued in their name by the department or its designee. A photocopy, duplicate copy or computer printout of this permit will suffice as evidence of receiving such permit.

(b) In San Juan county, in a posted portion of the San Juan river, from a point beginning approximately 1/4 mile downstream of Navajo dam and extending downstream 3.5 miles to the east side of section 16: the daily bag limit shall be 1 trout and no more than 1 trout shall be in possession except in the catch-and-release section. The angler must stop fishing in the section defined once the daily bag limit is reached.

(c) On those sections of the following waters every person must comply with any special requirements listed and no fish may be kept or held in possession while fishing in the posted portions of the following waters: In San Juan county: a posted portion of the San Juan river from Navajo dam downstream approximately 1/4 mile; In Sandoval county: a posted portion of the Rio Cebolla from the Seven Springs day use area upstream to its headwaters; In Sandoval county: a posted portion of the San Antonio River from the Baca location boundary downstream approximately 2.0 miles (T. 19 N., R. 03 E., S 16 and 20); In Sandoval county: a posted portion of the Rio Guadalupe from the Porter landing bridge downstream approximately 1.3 miles to Llano Loco Spring; In Taos county: a posted portion of the Rio Costilla from the Valle Vidal tract of the Carson national forest downstream for approximately 2.4 miles to the confluence of Latir creek; In Sierra county: the Rio las Animas within the Gila national forest, Black range ranger district; In Mora county: the Pecos river in the Pecos wilderness, above Pecos falls; In Rio Arriba county: Nabor creek and Nabor lake on the Edward Sargent wildlife area; In San Miguel and Santa Fe counties: Doctor creek from 1/4 mile above its confluence with Holy Ghost creek upstream to its headwaters; In Mora county: Rio Valdez in the Pecos wilderness from 1/4 mile below Smith cabin upstream to its headwaters; In San Miguel and Mora counties: Jack's creek from the water falls located 1/4 mile downstream of NM Highway 63 crossing upstream to its headwaters; In Taos and

Colfax counties: any stream on the Valle Vidal (Vermejo tract - Carson national forest); In Grant county; Black canyon creek in Grant county upstream from lower Black canyon campground. Every person angling for fish on this portion of Black canyon must be in possession of a Gila trout permit, issued in their name by the department or its designee. A photocopy, duplicate copy or computer printout of this permit will suffice as evidence of receiving such permit.

(d) In Colfax county: on a posted section of the Cimarron river from the lower end of Tolby campground downstream approximately 1.4 miles to the first bridge of N.M. 64 the daily bag limit shall be 1 fish and no more than one fish may be in possession.

(e) At Conservancy park/Tingley beach in Albuquerque: the southernmost pond shall be catch-and-release only.

(5) On the following waters, the daily bag limit shall be 3 trout and no more than 3 trout may be in possession, although there are no special restrictions regarding the use of legal gear.

(a) In Taos county: a posted portion of the Rio Grande beginning at the New Mexico/Colorado state line downstream to the Taos junction bridge.

(b) In Taos county: a posted portion of the Red River beginning approximately 1/2 mile downstream of the walking bridge at Red River state fish hatchery downstream to its confluence with the Rio Grande.

(c) In Taos county: the designated fishing pond at Red River state fish hatchery.

(d) In Rio Arriba county: on a posted portion of the Rio Chama from the base of Abiquiu dam downstream approximately 7 miles to the river crossing bridge on U.S. 84 at Abiquiu.

(e) In Sierra county: the Rio Grande from Elephant Butte dam downstream to and including Caballo lake.

(f) In Lincoln county: The Rio Ruidoso from the boundary between the Mescalero Apache reservation and the city of Ruidoso downstream to Fridenbloom drive.

(g) In Rio Arriba county: Burns canyon lake at Parkview hatchery.

(h) In Taos county: the Red River city ponds.

(6) Gila trout: It shall be unlawful for any person to possess Gila trout (*Oncorhynchus gilae*).

B. Warm-water fishes: The daily bag limit for game fish other than trout shall be as listed below and the possession limit shall be twice the daily bag limit.

(1) striped bass 3 fish;

(2) largemouth, smallmouth, and spotted bass 5 fish;

(3) walleye 5 fish;

(4) crappie 20 fish;

(5) white bass and white bass x striped bass hybrid 25 fish;

(6) northern pike 10 fish;

(7) catfish (all species, except bullheads) 15 fish;

(8) yellow perch 30 fish;

(9) all other warm-water game species 20 fish.

C. The following exception shall apply:

(1) At Conservancy park/Tingley beach in Albuquerque; lake Van (Chaves county); Oasis state park; Greene Acres lake (Curry county); Burn lake (Dona Ana county); Escondida lake (Socorro county); McGaffey lake (McKinley county); Bataan lake (Eddy county); Chaparral lake (Lea county); Bosque Redondo (De Baca county); Carrizozo lake (Lincoln county); Green Meadow lake; Eunice lake; and Jal lake (Lea county): the daily bag limit for channel catfish will be 2 fish and the possession limit shall be twice the daily bag limit.

(2) In San Juan county, in the San Juan and Animas rivers, not including Navajo lake, there is no daily bag limit or possession limit for channel catfish and striped bass.

(3) Statewide, all tiger muskie (*Esox lucius x E. masquinongy*) caught must immediately be released.

(4) In Eddy county, the Pecos river beginning at the north boundary of Brantley wildlife management area to Brantley reservoir dam including Brantley reservoir, all fish caught must immediately be released, except during official fishing tournaments during which fish may be held in a live well until they are weighed and measured, on site, and then immediately released back into the lake.

[19.31.4.11 NMAC - Rp 19.31.4.11 NMAC, 4-15-02; A, 10-31-02; A, 6-25-03; A, 8-13-04; A, 5-13-05; A, 9-15-05; A/E, 01-03-06; A, 1-31-06; A/E, 3-31-06; A/E, 5-31-06; A, 5-1-07]

19.31.4.16 CLOSED WATERS:

A. Waters closed to fishing

(1) In Catron county: Big Dry creek from Golden link cabin upstream through its headwaters.

[~~**(2) In Catron county: Iron creek from the "barrier" upstream to its headwater in the Gila wilderness.**~~]

[~~**(3)**~~] **(2)** In Catron county: Little creek from the "barrier" upstream through all tributaries.

[~~**(4)**~~] **(3)** In Catron county: McKenna, and Spruce and Sacaton creeks.

[~~**(5)**~~] **(4)** In Catron and Sierra counties: Main Diamond creek above the point of confluence with east fork of Diamond creek and the south Diamond creek drainage.

[~~**(6)**~~] **(5)** In Colfax county: a posted area lying within 300 feet of Eagle Nest dam, which is closed to entry.

[~~**(7)**~~] **(6)** In Colfax county: a posted area of Stubblefield and Laguna Madre lakes lying within 150 feet of the outlet structures.

[~~**(8)**~~] **(7)** In Grant county: east fork of Mogollon creek upstream of waterfalls near FS Trail No. 153, including Trail canyon, south fork Mogollon, and Woodrow canyon creeks.

[~~**(9)**~~] **(8)** In Grant county: McKnight creek.

[~~**(10)**~~] **(9)** In Grant county: Sheep corral creek.

[~~**(11)**~~] **(10)** In Lincoln county: posted areas of Alto reservoir and Bonito lake near the outlets.

[~~**(12)**~~] **(11)** In Catron county: White creek from waterfall near White creek cabin upstream to headwaters.

[~~**(13) In Grant county: Black canyon from "barrier" upstream to headwaters, including Aspen canyon and Fall canyon creeks.**~~]

[~~**(14)**~~] **(12)** In Catron county: West fork of the Gila river and all tributaries above waterfalls between FS Trail No. 151 crossing of the West fork of the Gila river near White creek cabin and FS Trail No. 151 crossing of the West fork of the Gila river near Lilley canyon.

[~~**(15)**~~] **(13)** In Sandoval county: Capulin creek on Bandelier national park and the Dome wilderness.

B. Taking fish from hatchery waters: No person shall take or attempt to take fish from the waters of any fish hatchery or rearing ponds owned and operated by state or federal agencies. During open season, however, angling for trout shall be permitted in the Glenwood pond at the Glenwood state fish hatchery, Red River hatchery pond at the Red River state fish hatchery, Brood pond at Seven Springs hatchery, and Burns canyon lake at Parkview state fish hatchery. Additionally, the director may expressly authorize other limited fishing at the state's fish hatcheries based on management needs.

C. Taking fish from or through the ice: Fish may be taken from or through the ice except on the following waters: Santa Cruz lake, Monastery lake, and Springer lake.

[19.31.4.16 NMAC - Rp 19.31.4.16 NMAC, 4-15-02; A, 6-25-03; A/E, 3-31-06; A/E, 7-18-06; A, 5-1-07]

NEW MEXICO DEPARTMENT OF GAME AND FISH

Explanatory paragraph: This is an amendment to 19.31.14 NMAC, Section 15, effective 5-1-2007. This amendment corrects the hunt start dates so that the private land hunts listed in Subsection F, Paragraph (6) match the hunt start dates for the corresponding public hunt start dates listed in Subsection F, Paragraph (4).

19.31.14.15 ELK HUNTS in COER GMUs: This section lists elk management information and subsequent hunting opportunities for GMUs in elk regions where a core occupied elk range has been established. The listed information includes elk population information, management goals, harvest objectives, total number of hunting opportunities, GMUs or areas open for hunting, season dates, hunt codes, bag limits, legal weapons, number of licenses available in the public draw and the number and type of authorization certificates available for private lands within the COER of each GMU. Hunt codes for elk hunts allowing the "any legal weapon" type shall be designated ELK-1, hunt codes for elk hunts allowing the "bow only" weapon type shall be designated as ELK-2, hunt codes for elk hunts allowing the "muzzle loading rifles or bow" weapon type shall be designated as ELK-3. Youth hunters must provide hunter education certification number on application. Military only hunters must be full time active military and proof of military status must accompany application. Proof of this service is required. Mobility impaired hunt applicants shall meet eligibility requirements, as designated by the director, prior to applying for mobility impaired hunts.

F. SOUTH CENTRAL REGION GMUs 34 and 36.

(1) Quality hunt management for GMU 36.

(2) Optimal opportunity management goals for GMU 34.

(3) Foundational resource information for the south central region shall be as indicated below.

GMU	mgmt goal	population information		sustainable harvest pursuant to goals		total licenses by bag limit				projected harvest	
		popn est.	bull:cow: calf ratio	bulls	cows	MB	A	ES bow	total lic.	bull	cow
34	OOM	1705 - 2255	60:100:30	117	126	690	690	460	1840	195	223
36	QHM	1195 - 1880	38:100:27	81	101	425	220	228	873	96	71
Totals		2900 - 4135	49:100:28	198	227	1115	910	688	2713	290	294

(4) Public land elk hunts listing the hunt dates, hunt code, number of licenses, bag limits, and weapon types, shall be as indicated below.

open GMUs or areas	2007 - 2008 hunt seasons		2008 - 2009 hunt seasons		hunt code	licenses	bag limit
	hunt start	hunt end	hunt start	hunt end			
34	09/01/2007	09/22/2007	09/01/2008	09/22/2008	ELK-2-306	400	ES
34 YO	09/29/2007	10/03/2007	09/27/2008	10/01/2008	ELK-1-307	150	ES
34 MI	09/29/2007	10/03/2007	09/27/2008	10/01/2008	ELK-1-308	50	MB
34	10/06/2007	10/10/2007	10/04/2008	10/08/2008	ELK-3-309	250	MB
34	10/13/2007	10/17/2007	10/11/2008	10/15/2008	ELK-1-310	150	MB
34	11/24/2007	11/28/2007	11/22/2008	11/26/2008	ELK-1-311	250	A
34	12/01/2007	12/05/2007	11/29/2008	12/03/2008	ELK-1-312	250	A
34 web sale	TBD	TBD	TBD	TBD	ELK-1-313	100	A
36	09/01/2007	09/22/2007	09/01/2008	09/22/2008	ELK-2-314	148	ES
36	10/06/2007	10/10/2007	10/04/2008	10/08/2008	ELK-3-315	125	MB
36	10/13/2007	10/17/2007	10/11/2008	10/15/2008	ELK-1-316	75	MB
36	10/13/2007	10/17/2007	10/11/2008	10/15/2008	ELK-1-317	143	A
36	10/27/2007	10/31/2007	10/25/2008	10/29/2008	ELK-1-318	76	MB
36 web sale	TBD	TBD	TBD	TBD	ELK-1-319	0	A

(5) Private land elk authorization certificates for qualifying ranches listing the number of authorization certificates, bag limits, and weapon types, shall be as indicated below.

open GMUs or areas	2007 - 2008 hunt season				2008 - 2009 hunt season			
	bull	antlerless	ES bow only	total	bull	antlerless	ES bow only	total
34	90	90	60	240	90	90	60	240
36	149	77	80	306	149	77	80	306
Total	239	167	140	546	239	167	140	546

(6) Private land elk hunts for ranches designated as "RANCH ONLY" shall be limited to the following season dates and legal sporting arms. All private land mobility impaired and youth only hunters must satisfy licensing requirements as stated in 19.31.3 NMAC, in order to hunt during the "mobility impaired hunters" or "youth only" hunt periods.

legal sporting arms	open GMUs or area	2007 - 2008 hunt dates	2008 - 2009 hunt dates
bows only	34, 36	09/01/2007 - 09/22/2007	09/01/2008 - 09/22/2008
any legal sporting arms, YO & MI only	34	[~~10/06/2007 - 10/10/2007~~] 09/29/2007 - 10/03/2007	[~~10/04/2008 - 10/08/2008~~] 09/27/2008 - 10/01/2008
muzzle loading rifles and bows	34, 36	any 5 consecutive days, [~~10/13/2007 - 12/31/2007~~] 10/06/2007 - 12/31/2007	any 5 consecutive days, [~~10/11/2008 - 12/31/2008~~] 10/04/2008 - 12/31/2008
any legal sporting arms	34, 36	any 5 consecutive days, [~~10/20/2007 - 12/31/2007~~] 10/13/2007 - 12/31/2007	any 5 consecutive days, [~~10/18/2008 - 12/31/2008~~] 10/11/2008 - 12/31/2008
rifles only	36 with approval of SE area chief and state game commission chairman. Antlerless elk only	any 5 consecutive days 01/01/2008 -01/31/2008	any 5 consecutive days 01/01/2009 -01/31/2009

[19.31.14.15 NMAC - Rp, 19.31.8.13 & 24 NMAC, 4-1-2007; A, 5-1-2007]

NEW MEXICO OFFICE OF GUARDIANSHIP

This is an amendment to 9.21.4 NMAC Sections 7, 8, 11, 12, & 14. New Section 18 is being added. Effective 04/30/07.

9.4.21.7 DEFINITIONS: The following words and terms when used in this part shall have the following meanings unless the context clearly indicates otherwise.

A. "Complaint" means an allegation of wrongdoing by a contractor or a violation of the contract with the office of guardianship and the contractor, including but not limited to:

(1) failure to provide appropriate services;

(2) violations of the civil rights of the wards; and

(3) abuse, neglect or exploitation of the ward.

B. "**Comprehensive evaluation**" is an assessment using a variety of diagnostic tools to determine the appropriate level of intervention, if any, in order to maximize self-reliance and independence for a ward as mandated by NMSA 1978, Section 45-5-301.1.

[~~T.~~] C. "Contracted guardianship providers" means some private/public entity under contract with the NMDDPC office of guardianship to act as guardian for an adjudicated incapacitated person who has no family or friends willing, able and appropriate to be his/her[~~/her~~] guardian.

[~~C.~~] D. "Contractor" means an entity under a contract with the NMDDPC office of guardianship to provide some type of guardianship service; i.e., attorneys, court visitors, or guardians.

[~~B.~~] E. "Court" means the district court or family division of the district court where such jurisdiction is conferred.

F. "**Designated entity**" is a person or organization contracted or appointed by the NMDDPC office of guardianship to conduct the comprehensive evaluations.

[~~D.~~] G. "Emergency" means any situation in which the physical or mental condition, health status or safety of an incapacitated person is at significant risk due to the unavailability of a substitute decision maker.

[~~E.~~] H. "Functional impairment" means an impairment that is measured by a person's inability to manage his/her personal care or the person's inability to manage his/her estate or financial affairs or both.

[~~F.~~] I. "Grievance" means an allegation of wrongdoing by the office of guardianship or its staff, including but not limited to:

(1) failure to appropriately monitor and supervise contractors;

(2) violations of the due process rights of the ward or contractor; and

(3) failure to comply with complaint procedures as set forth herein.

[~~G.~~] J. "Guardian" means a person who has qualified to provide for the care, custody or control of [~~the person of~~] an incapacitated person pursuant to testamentary or court appointment, but excludes one who is a guardian ad litem.

[~~H.~~] K. "Guardian ad litem" means an attorney appointed by the court to represent and protect the interests of an incapacitated person in connection with litigation or any other court proceeding.

[~~J.~~] L. "Inability to manage his/her personal care" means the inability, as evidenced by recent behavior, to meet one's needs for mental or physical health treatment or care resulting in personal neglect of medical care, nutrition, shelter, hygiene or safety so that physical injury, illness or disease has occurred or is likely to occur in the near future.

[~~I.~~] M. "Incapacitated person" means any person who is found by a court to be impaired to the extent that he/she lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his/her/[~~her~~] person or management of his/her/[~~her~~] affairs.

[~~K.~~] N. "Interested person" means any person who has an interest in the welfare of the alleged incapacitated adult to be protected, and may include the NMDDPC office of guardianship.

[~~L.~~] O. "Least restrictive form of intervention" means only those limitations necessary to provide the needed care and rehabilitative services, and that the adjudicated incapacitated adult shall enjoy the greatest amount of personal freedom and legal rights.

[~~M.~~] P. "Letters" means letters of guardianship, which provide proof that the guardian of the adjudicated incapacitated adult is a court appointed guardian.

[~~N.~~] Q. "Limited guardian" means a guardian appointed by the court to exercise limited authority for the incapacitated person as specified in the court order.

[~~O.~~] R. "Limited guardianship" means the court shall appoint a limited guardian if it determines that the incapacitated person is able to manage some but not all aspects of his/her personal care. The court shall specify those powers that the limited guardian shall have and may further restrict each power so as to permit the incapacitated person to care for himself commensurate with his/her ability to do so. A person for whom a limited guardian has been appointed retains all legal rights except those that have been specifically granted to the limited guardian by the court.

[~~P.~~] S. "Petitioning attorney" means the attorney who files a petition on behalf of the interested person and represents the interested person and identifies the proposed guardian.

[~~Q.~~] T. "Plenary guardian" or "full guardian" means a guardian appointed by the court to exercise all legal rights and powers of the incapacitated per-

son after the court has found that the incapacitated person lacks the capacity to carry out all the tasks necessary to care for his or her person.

[R.] U. "Plenary guardianship" or **"full guardianship"** means the most restrictive form of guardianship and is authorized by a court only when an alleged incapacitated person is found to lack capacity to carry out all of the tasks necessary to care for his or her person and only after less restrictive options have been ruled out.

[S.] V. "Power of attorney (POA)" means a document created while a person (principal) has capacity, which grants revocable authority to another person (agent) to act on behalf of the principal in specified areas.

(1) "Durable POA" means the document has language which indicates that it will not be affected by any subsequent incapacity of the principal. Thus, it is considered to be a durable power of attorney.

(2) "Springing POA" means the document contains language which indicates that it only becomes effective upon the incapacity of the principal. Thus, it is considered to be a springing power of attorney.

[DD.] W. "Qualified health care professional" means a physician, psychologist, nurse practitioner or other health care practitioner whose training and expertise aid in the assessment of functional impairment.

[U.] X. "RFP" means the request for proposal which is the process under State Procurement Code where an individual or [other] non-state agency entity may be awarded a contract to provide services.

[V.] Y. "Substitute judgment" means the standard of decision making for guardians of adults that requires the guardian to ascertain what the decision would have been if the ward were able to make the decision themselves and then make the decision based upon that knowledge.

[W.] Z. "Surrogate decision maker" means the individual authorized by the Uniform Health Care Decisions Act to make health care decisions for a patient.

[X.] AA. "Temporary guardian" means a person appointed by the court at an expedited hearing to serve as guardian for an alleged incapacitated person. The temporary guardian has specific powers granted by the court to prevent harm to the alleged incapacitated person during the time of his or her appointment.

[Y.] BB. "Temporary guardianship" means that when a petition for guardianship has been filed alleging that immediate and irreparable harm will result to the alleged incapacitated person if the normal notice and time requirements of a guardianship proceeding are kept, [and] the court may appoint a temporary guardian for the alleged incapacitated person without notice to the alleged incapacitated person. The temporary guardianship shall last not more than sixty days although the court can extend the guardianship for an additional thirty days. A hearing shall be held to determine whether the guardianship will be permanent.

[Z.] CC. "Testamentary guardian" means a guardian appointed by will or other writing of a parent or spouse guardian pursuant to the procedures outlines in NMSA 45-5-301.

[AA.] DD. "Testamentary guardianship" means a guardianship that is passed from a spouse or parent guardian to another person through a will or other writing pursuant to the procedures outlined in NMSA 45-5-301.

[BB.] EE. "Treatment guardian" means a person, appointed by the court pursuant to the Mental Health and Developmental Disabilities Code (NMSA Section 43-1-15), who can make substitute decisions for an incapacitated person regarding mental health treatment, including the use of psychotropic medications, for a specified period of time, not to exceed one year per court appointment.

[CC.] FF. "Treatment guardianship" means a form of guardianship tailored to grant the guardian authority to make decisions regarding mental health treatment for individuals determined by the court to lack the capacity to provide informed consent for mental health treatment.

[EE.] GG. "Visitor" or "court visitor" means a person who is an appointee of the court who has no personal interest in the proceeding and who has been trained or has the expertise to appropriately evaluate the needs of the person who is allegedly incapacitated. A "visitor" may include, but is not limited to, a psychologist, social worker, developmental incapacity professional, physical [and] or occupational therapist, an educator [and] or a rehabilitation worker.

[FF.] HH. "Ward" means an incapacitated person for whom a guardian has been appointed.

[9.4.21.7 NMAC - N, 4/14/2006; A, 4/30/07]

9.4.21.8 ELIGIBILITY:

A. The alleged incapacitated person must be eighteen (18) years old to qualify for services from the NMDDPC office of guardianship.

B. The alleged incapacitated person must be financially eligible for institutional medicaid.

C. For a guardianship where the proposed guardian is not a contracted service provider, to obtain legal services the proposed guardian's gross income must not exceed three hundred percent (300%) of the federally established poverty level as that term is defined by the federal HHS poverty guidelines.

(1) Proof of income is required and is determined in one of two ways:

(a) providing the NMDDPC a copy of the proposed guardian's federal income tax return (first two pages of 1040 or 1041) for the year prior to the year in which application is made; or

(b) proof of qualification by the proposed guardian under any federal or state program with income restrictions equal to or greater than that required above.

(2) At the discretion of the director of the NMDDPC office of guardianship, exceptions may be made for financial hardship.

(3) The NMDDPC may develop a sliding-fee scale for private guardianships for persons who do not meet income eligibility guidelines.

[C.] D. The alleged incapacitated person must be a legal resident of New Mexico.

[D.] E. The alleged incapacitated person must be recently assessed by a qualified health care provider who shall submit a report in writing to the court, which:

(1) describes the nature and degree of the alleged incapacitated person's incapacity, if any, and the level of the alleged incapacitated person's intellectual, developmental and social functioning; and

(2) includes observations[,] and supporting data regarding the alleged incapacitated person's ability to make health care decisions and manage the activities of daily living. NMSA Section 45-5-303D (1993)

[9.4.21.8 NMAC - N, 4/14/2006; A, 4/30/07]

9.4.21.11 SERVICES TO BE PROVIDED BY THE NMDDPC OFFICE OF GUARDIANSHIP:

A. The provision of probate code guardianship services to income eligible, incapacitated persons as follows:

(1) contracting with attorneys to petition for the appointment of probate code guardians;

(2) contracting with entities/individuals to serve as probate code guardians;

[~~(3) contracting with entities/individuals to serve as probate code guardians;~~]

[~~(4)~~] **(3)** contracting with visitors (court visitors) in probate code proceedings;

[~~(5)~~] **(4)** contracting with attorneys to serve as guardian ad litem in probate court proceedings;

[~~(6)~~] **(5)** identifying available persons to serve as mental health treatment guardian;

[~~(7)~~] **(6)** contracting to provide for recruitment and training for persons interested in serving as mental health treatment guardians;

[~~(8)~~] **(7)** providing information regarding the duties and responsibilities of probate code guardianship, including less restrictive alternatives; and

[~~(9)~~] **(8)** investigating and addressing complaints made against the office of guardianship contractors.

B. The provision of recruitment and training for persons interested in serving as guardians.

C. The provision of information regarding the duties and responsibilities of guardianship, including less restrictive alternatives.

D. The provision of investigative measures/ processes to address complaints made against entities providing contracted guardianship services.

[9.4.21.11 NMAC - N, 4/14/2006; A, 4/30/07]

9.4.21.12 REQUIREMENTS OF CONTRACTED GUARDIANSHIP PROVIDERS:

A. meet RFP Requirements when published;

B. meet office of guardianship requirements including but not limited to[~~:~~]:

[~~C.~~] **(1)** comply with all the terms of one's contract;

[~~D.~~] **(2)** agree to be paid at the state approved rate;

[~~E.~~] **(3)** must comply with the Caregivers Criminal History Screening Act (See NMSA, 1978 29-17-2);

[~~F.~~] **(4)** must become a registered guardian within 18 months after the award of a contract;

[~~G.~~] **(5)** assure the civil rights of the incapacitated persons;

[~~H.~~] **(6)** guarantee access to all records on incapacitated persons assigned through the office of guardianship; and

[~~I.~~] **(7)** comply with the office of guardianship individual caseloads, standards of practice and ethics.

[9.4.21.12 NMAC - N, 04/14/2006; A, 4/30/07]

9.4.21.14 COMPLAINTS AGAINST A CONTRACTED PROVIDER WITH THE OFFICE OF GUARDIANSHIP:

A. A complaint shall be made in writing by the client or another person on behalf of the client, including but not limited to a friend, relative, advocate, or other interested person, such as a caregiver or provider. An exception to the requirement that a complaint shall be made in writing shall be made if a reasonable accommodation is necessary.

B. With the exception set forth in Subsection E of 9.4.21.14 NMAC, below, all individuals registering a complaint shall first try and resolve their complaints against a contracted provider with the office of guardianship.

C. If the complaining party and contractor are unable to reach a resolution or agreement then the complaining party may file a complaint with the office of guardianship and may file a copy with the contractor.

D. Complaining parties may file a simultaneous compliant against a contractor with the office of guardianship. The office of guardianship may choose to postpone intervention pending completion of the contractor's grievance process.

E. Exceptions shall be made to Subsections A & B of 9.4.21.14 NMAC when the office of guardianship has reason to believe that an emergency situation exists or that a delay of the investigation could result in harm to the ward or retaliation by the contractor.

F. The complaint should include as much information as possible, including the following:

(1) name of the incapacitated person;

(2) name of the contact information for the individual making the complaint on behalf of the incapacitated person;

(3) relationship of the complaining party to the incapacitated person;

(4) name of the individual contractor against whom the complaint is being made;

(5) name of the party who has attempted to resolve the complaint, if known;

(6) details of the complaint including the alleged wrongdoing, the involved parties and when and where the wrongdoing occurred;

(7) where sufficient information is provided to allow the office of guardianship to continue the investigation, the office of guardianship will make further inquiries if possible or discontinue the investigation; justification for closure of investigations based on insufficient information will be documented.

G. The complaint made to the office of guardianship may be submitted by mail or fax unless a reasonable accommodation is necessary.

H. In order to preserve the confidentiality of the incapacitated person, the complaint shall be submitted to: The NMDDPC Office of Guardianship; 810 W. San Mateo, Ste. C; Santa Fe, NM 87505-4144; (505) 476-7324; (505) 476-7322 (Fax).

I. Upon receipt of a verbal or written complaint, the office of guardianship shall:

(1) acknowledge receipt of a the complaint in writing;

(2) notify all parties involved; and

(3) initiate an investigation within 15 working days of the filing of the complaint with the office of the guardianship.

J. A determination decision shall be made within 60 working days after the complaint is filed with the office of guardianship unless a shorter time frame is required to protect the ward.

K. A determination decision shall include:

(1) the decision made;

(2) the basis for the decision;

(3) notice of the complaining party's right to [~~grieve~~] file a complaint about the actions taken by the office of guardianship related to the investigational process pursuant to 9.4.21.15 NMAC.

(4) further actions to be taken by the office of guardianship and the contractor which may include, but shall not be limited to:

(a) the [~~institution~~] imposition of a corrective action plan [~~and~~] on the contractor; and

(b) a referral of the complaint to other agencies for investigation and prosecution.

L. Persons objecting to the process of the complaint investigation taken by the office of guardianship may file a grievance against the office of guardianship with the New Mexico human services department pursuant to 9.4.21.15 NMAC below.

M. None of these regulations restrict the due process rights of an individual to request a less restrictive guardianship or to overturn the decision of a guardianship contractor or the office of guardianship through a court of law.

[9.4.21.14 NMAC - N, 04/14/2006; A. 04/30/07]

9.4.21.18 COMPREHENSIVE EVALUATIONS:

A. Comprehensive evaluations for wards with contracted providers will occur in the following circumstances:

(1) no comprehensive evaluation has occurred in the last five years;

(2) comprehensive evaluations may occur sooner then every five years upon mutual agreement between the NMDDPC office of guardianship and a contracted guardianship provider;

(3) life circumstances resulting in change in condition.

B. Comprehensive evaluations will occur in the following manner.

(1) The comprehensive evaluations will be done by the entity designated by the NMDDPC office of guardianship.

(2) Within thirty (30) days after the professional services contract is signed, all contracted guardianship providers will provide the names of their wards who have not had a comprehensive evaluation in the last five (5) years to the NMDDPC office of guardianship.

(3) The components of the comprehensive evaluation will be determined by the designated entity after consultation with the guardian.

(4) The designated entity will set up the appointments.

(5) The contracted guardianship provider will provide written authorization for the wards selected for a comprehensive evaluation.

(6) The contracted guardianship provider will provide the following documents at a time and place determined by the designated entity:

(a) name of the ward, living arrangements of the ward, day placement and daily activity, and relevant contact information;

(b) medical history and assessment history of the ward that may come from other state and federal programs such as the DD Waiver program, medicaid, schools, division of vocational rehabilitation, commission for the blind, etc.;

(c) the current level of guardianship, and;

(d) any additional information requested by the designated entity relevant to the comprehensive evaluation.

(7) These provisions are in addition to any terms and conditions regarding comprehensive evaluations as set forth in the contract between the NMDDPC office of guardianship and the contracted guardianship provider.

(8) If a ward has undergone some part of the comprehensive evaluation within the last three years, the contracted guardianship provider may request to substitute that part of the evaluation for the report of the evaluation undergone within the last three (3) years. The designated entity may deny the request, based on professional judgment, it should not be substituted. If a substitution is allowed, the contracted guardianship provider will provide the report of that evaluation to the designated entity.

(9) If the contracted guardianship provider has clear and convincing evidence that a ward does not need an evaluation, the contracted guardianship provider will provide to the NMDDPC office of guardianship a short description explaining why the ward should not be evaluated.

(10) The NMDDPC office of guardianship or its agent has the right to review the files and records of any ward under contract between the NMDDPC office of guardianship and a contracted guardianship provider for the purpose of determining whether the ward should have a comprehensive evaluation.

(11) If the NMDDPC office of guardianship determines that a ward should undergo an evaluation, despite the justification provided in Paragraph (9) of Subsection B of 9.4.21.18 NMAC, the NMDDPC office of guardianship will send a letter to the contracted guardianship provider so stating ("Notice Letter"). If, after receipt of the notice letter, the contracted guardianship provider does not agree with the NMDDPC office of guardianship that a ward should undergo an evaluation, the following procedure will commence.

(a) Within ten (10) working days after receiving the notice letter, the contracted guardianship provider will contact the NMDDPC office of guardianship in writing with the basis for its disagreement with the notice letter and during that same time period set up a meeting at the office of the NMDDPC office of guardianship for the purpose of attempting to resolve this issue. The contracted guardianship provider attending the meeting must have full authority to resolve this issue. The proposed location of the meeting will be at the office of the NMDDPC office of guardianship at a day and time proposed by the NMDDPC office of guardianship. The contracted guardianship provider may propose a different time and location. The meeting must be held no more than thirty (30) days from the date of receipt of the notice letter. If the parties cannot agreed on a location and time, the NMDDPC office of guardianship may petition the court pursuant to Subparagraph (d) of Paragraph (11) of Subsection B of 9.4.21.18 NMAC.

(b) If the parties come to an agreement, the ward may or may not undergo an evaluation depending on the agreement reached by the parties.

(c) The NMDDPC office of guardianship will confirm the outcome of the meeting by letter (outcome letter) within two working days of the meeting between the parties.

(d) If there is no agreement, the NMDDPC office of guardianship may, within fourteen (14) working days from the date of the outcome letter, petition the court in which the guardian was appointed to have the ward evaluated.

[9.4.21.18 NMAC - N, 04/30/07]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.313.2 NMAC, Sections 6, 8, 10, 13, 17 through 20, which will be effective on May 1, 2007. The Medical Assistance Division amended the sections in order to change the number of reserved bed days available per calendar year for all ICF-MR residents without prior authorization, the documentation required for all reserve bed days, prior authorization requirements and the documentation required for all absences from an ICF-MR.

8.313.2.6 OBJECTIVE: The objective of these regulations is to [~~provide policies for~~] govern the service portion of the New Mexico medicaid [~~program~~] and medical assistance programs. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[2-1-95; 8.313.2.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 11-1-00; A, 5-1-07]

8.313.2.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of [~~Medicaid~~] HSD/MAD program eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[2-1-95; 8.313.2.8 NMAC - Rn, 8 NMAC 4.MAD.002, 11-1-00; A, 5-1-07]

8.313.2.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by New Mexico medical assistance division (MAD), intermediate care facilities for the mentally retarded (ICF-MR) which meet the following conditions for participation are eligible to be reimbursed for providing services to eligible medicaid recipients:

(1) the ICF-MR must be licensed and certified by the division of health improvement, health facility licensing and certification bureau of the New Mexico department of health (DOH) to meet the intermediate care facility requirements. See 42 CFR 483 Subpart I;

(2) the ICF-MR must [~~conform to policy, regarding Medicaid~~] comply with 8.313.2.17 NMAC, *Recipient Personal [~~Funds~~] Fund Accounts*; and

(3) the ICF-MR must participate in the MAD utilization review process and must agree to operate in accordance with all policies and procedures of that system, including the performance of discharge planning.

B. [~~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 new materials are received from MAD~~.] Once enrolled, providers receive instruction on how to access medicaid and other medical assistance provider program policies, billing instructions, utilization review instructions, and other pertinent material. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements. To be eligible for medical assistance program reimbursement, providers are bound by the provisions of the provider participation agreement.

[2-1-95; 8.313.2.10 NMAC - Rn, 8 NMAC 4.MAD.732.1, 11-1-00; A, 5-1-07]

8.313.2.13 PROVIDER RESPONSIBILITIES:

A. Providers who furnish services to [~~Medicaid~~] HSD/MAD program eligible recipients must comply with all specified [~~Medicaid~~] HSD/MAD participation requirements. See Section MAD-701, *General Provider Policies*.

B. 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 must maintain [~~records which are sufficient to fully disclose the extent and nature of the services furnished to recipients~~] any and all medical or business records as necessary to fully disclose the type and extent of services provided to recipients. See Section MAD-701, *General Provider Policies*.

[2-1-95; 8.313.2.13 NMAC - Rn, 8 NMAC 4.MAD.732.2, 11-1-00; A, 5-1-07]

8.313.2.17 RECIPIENT PERSONAL FUND ACCOUNTS:

A. As a condition for participation in medicaid, each ICF-MR must establish and maintain an acceptable system of accounting for a resident's personal funds when a Title XIX (medicaid) recipient requests that his or her personal funds be cared for by the facility. See 42 CFR 483.10(c).

(1) Requests for ICFs-MR to care or not care for a resident's funds must be made in writing and secured by a request to handle recipient's fund form or a letter signed by the resident or his/her representative. The form or letter is retained in the recipient's file at the facility.

(2) A recipient's personal fund consists of a monthly maintenance allowance established by MAD. If the resident receives any income in excess of this allowance, the excess is applied to the cost of the resident's medical care at the facility. This excess is reported as a medical care credit to the facility by the local county income support division (ISD) office, when applicable.

(3) All facilities must have procedures on the handling of medicaid residents' funds. These procedures must not allow the facility to commingle medicaid residents' funds with facility funds.

(4) Facilities should use these medicaid guidelines to develop procedures for handling resident funds.

(5) Residents have the right to manage their financial affairs and no facility can require residents to deposit their personal funds with the facility.

(6) Facilities must purchase a surety bond or provide self-insurance to ensure the security of all personal funds deposited with the facility.

B. **Fund custodians**: Facilities must designate a full-time employee and an alternate to serve as fund custodians for handling all medicaid residents' money on a daily basis. Another individual, other than those employees who have daily responsibility for the fund, must do the following:

(1) reconcile balances of the individual medicaid residents' accounts with the collective bank account;

(2) periodically audit and reconcile the petty cash fund; [~~and~~]

(3) authorize checks for the withdrawal of funds from the bank account; and

(4) facilities must ensure that there is a full, complete and separate accounting, based on generally accepted accounting principles, of each resident's personal funds entrusted to facilities on the resident's behalf.

C. **Bank account**: Facilities must establish a bank account for the deposit of all medicaid residents who request the facility to handle their funds. Residents' personal funds are held separately and not commingled with facility funds.

(1) Facilities must deposit any resident's personal funds of more than fifty dollars ($50) in an interest bearing account that is separate from any of the facility operating accounts and which credits all interest earned on the resident's account to that account.

(2) Facilities must maintain residents' personal fund up to fifty dollars ($50) in a non-interest bearing account or a petty cash fund. Residents must have convenient access to these funds.

(3) Individual financial records must be available on the request of residents or their legal representatives.

(4) Within [~~thirty (30)~~] 30 days of the death of residents whose personal funds are deposited with the facility, the ICF-MR must convey the resident's funds and a final accounting of these funds promptly to the individual or probate jurisdiction administering the resident's estate.

D. **Establishment of individual accounts**: Facilities must establish accounts for each medicaid resident in which all transactions can be recorded. Accounts can be maintained in a general ledger book, card file, or looseleaf binder.

(1) For money received, the source, amount, and date must be recorded. Residents or their authorized representatives must be given receipts for the money. The facility must retain a copy of the deposit in the resident's individual account file.

(2) The purpose, amount and date of all disbursements to or on behalf of residents must be recorded. Any money spent either on behalf of residents or withdrawn by residents or their representatives must be validated by receipts or signatures on individual ledger sheets.

(3) Facilities must notify each medicaid resident when the account balance is two hundred ($200) dollars less than the supplemental security income (SSI) resource limit for [~~one (1)~~] one person, specified in section 1611(a)(3)(B) of the Social Security Act. If the amount of the account and the value of the resident's other nonexempt resources reach the SSI resource limit for [~~one (1)~~] one person, the resident can lose eligibility for medicaid or SSI.

E. **Personal fund reconciliation**: Facilities must balance the individual accounts, the collective bank accounts and the petty cash fund at least once a month. The facility must provide medicaid residents or their authorized representatives with an accounting of the resident's funds at least once a quarter. Copies of individual account records can be used to provide this information.

F. **Petty cash fund**: Facilities must maintain a cash fund to accommodate the small cash requirements of medicaid residents. Five dollars ($5.00) or less per individual recipient may be adequate. The amount of money maintained in the petty cash fund is determined by the number of residents using the service and the frequency and availability of bank service. A petty cash fund ledger must be established to record all actions regarding money in this fund.

(1) To establish the fund, the ICF-MR must withdraw money from the collective bank account and keep it in a locked cash box.

(2) To use the petty cash fund, the

following procedures should be established:

(a) recipients or their authorized representatives request small amounts of spending money;

(b) the amount disbursed is entered on individual ledger record; and

(c) the resident or representative signs an account record and receives a receipt.

(3) To replenish the fund, the following procedures should be used:

(a) money in the cash box is counted and added to the total of all disbursements made since the last replenishment; and

(b) the total of the disbursements plus cash on hand equals the beginning amount;

(c) money equal to the amount of disbursements is withdrawn from the collective bank account.

(4) To reconcile the fund, the following procedures must be established and used at least once each month:

(a) count money on hand; and

(b) total cash disbursed either from receipts or individual account records; the cash on hand plus total disbursements equals the petty cash total.

(5) To close the resident's account, ICFs-MR should do the following:

(a) enter date of and reason for closing the account;

(b) write a check against the collective bank account for the balance shown on the individual account record;

(c) get signature of the recipient or their authorized representative on the individual recipient account record, as receipt of payment; [~~and~~]

(d) notify the local ISD office if closure is caused by the death of the recipient so that action can be taken to terminate assistance; and

(e) within 30 days of the death of a resident who had no relatives, the ICF-MR conveys the resident's funds and a final accounting of the funds to the individual or probate jurisdiction administering the resident's estate; see 42 CFR 483.10(c)(6).

G. **Retention of records**: All account records other than financial and statistical cost reports must be retained until after an audit is complete or [~~3~~] six years, whichever is greater. For details on retention of financial and statistical cost reports, see Subsection D of 8.313.3.12 NMAC *Retention of Records*.

H. **Non-acceptable uses of recipients' personal funds:**

(1) Facilities cannot impose charges against a resident's personal funds for any item or service for which payment is made by medicaid or for any item residents or their representatives did not request. Facilities must not require residents or representative to request any item or services as a condition of admission or continued stay.

(2) Facilities must inform residents or representative requesting non-covered items or services that there is a charge for the item and the amount of the charge.

(3) Non-acceptable uses of residents' personal funds include the following:

(a) payment for services or supplies covered by medicaid or medicare; see 8.313.3 NMAC, *Cost Related Reimbursement Of Intermediate Care Facilities For The Mentally Retarded*;

(b) difference between the facility billed charge and the medicaid payment; or

(c) payment for services or supplies routinely furnished by the facility, such as linens and nightgowns.

I. **State monitoring of residents' personal funds**: Facilities must make all files and records involving residents' personal funds available for inspection by authorized state personnel or federal auditors.

(1) [~~The Licensing and Certification Bureau~~] The division of health improvement, health facility licensing & certification bureau of the DOH verifies that facilities have a system of accounting for residents' personal funds, including the components described above. Failure to provide an acceptable accounting system constitutes a deficiency that must be corrected.

(2) The human services department (HSD) or its designee can complete a thorough audit of residents' personal fund accounts at HSD's discretion.

[2-1-95; 8.313.2.17 NMAC - Rn, 8 NMAC.MAD.732.6 & A, 11-1-00; A, 5-1-07]

8.313.2.18 LEVEL OF CARE DETERMINATION: Medical necessity, level of care or length of stay determinations, and on-site review activities are carried out in accordance with the MAD utilization review policy and procedures, authorized under Title XIX of the Social Security Act. See [~~Section MAD-955, RECONSIDERATION OF LEVEL OF CARE DETERMINATIONS~~] MAD-954 [8.350.3 NMAC], *Abstract Submission For Level Of Care Determinations*.

[2-1-95; 8.313.2.18 NMAC - Rn, 8 NMAC 4.MAD.732.8, 11-1-00; A, 5-1-07]

8.313.2.19 PRIOR [~~APPROVAL~~] AUTHORIZATION AND UTILIZATION REVIEW: All [~~Medicaid~~] HSD/MAD program 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 [~~Section MAD-705, PRIOR APPROVAL~~] 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. Prior [~~Approval~~] authorization: Certain procedures or services can require prior [~~approval~~] authorization from MAD or its designee. 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~~] HSD/MAD programs. Providers must verify that individuals are eligible for [~~Medicaid~~] HSD/MAD programs at the time services are furnished and determine if [~~Medicaid~~] HSD/MAD program 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 Section MAD-953, *Reconsideration Of Utilization Review Decisions*.

[2-1-95; 8.313.2.19 NMAC - Rn, 8 NMAC 4.MAD.732.9, 11-1-00; A, 5-1-07]

8.313.2.20 RESERVE BED DAYS: Medicaid pays to hold or reserve a bed for a resident of an ICF-MR for the following reasons: 1) to allow the resident to make [~~a brief home visit, e.g., vacation; 2) for acclimation to a new environment; 3) for hospitalization; or, 4) for habilitation purposes as part of a resident's individual program plan of service to maintain facility and community ties.~~

~~A. **Coverage of Reserve Bed Days**: Medicaid covers 65 reserve bed days per calendar year for every resident without prior approval. Reserve days may be used for habilitation purposes as part of a resident's individual program plan of service to maintain facility and community ties. The resident's habilitation plan must state the goal to be achieved by these visits and the manner in which this is to be accomplished. If the absence from the facility is not included in the resident's program plan, the reserve bed day payment will be recouped.~~

~~B. Medicaid covers an additional 6 reserve days per year with prior approval to enable residents to adjust to a new environment, if this is part of discharge planning.~~

~~(1) A resident's discharge plan must clearly state the objectives, including how home visits or visits to alternative placement relate to discharge implementation.~~

~~(2) A prior approval request must include the resident's name, Medicaid number, requested approval dates, copy of the discharge plan, name and address of the individual who will care for the resident and the written physician order for trial placement.~~

~~C. **Reserve Bed Days for Habilitation Purposes**: Medicaid covers an additional nine (9) days per calendar year for residents of ICFs-MR if the increased absence is included as part of a resident's individual program plan of service to maintain facility and community ties. The resident's habilitation plan must state the goal to be achieved by these increased visits and the manner in which this is to be accomplished. If the absence from the facility is not included in the resident's program plan, the reserve bed day payment will be recouped.~~

~~D. **Documentation of Reserve Bed Days**: If residents leave the ICF-MR for any reason, appropriate documentation must be placed in the resident's chart. A physician order must be obtained if residents are hospitalized, request home visits or request trial placement.~~

~~E. **Level of Care Determinations**: A new level of care determination must be made by the MAD utilization review (UR) contractor if the resident is gone from the ICF-MR for more than three (3) midnights. An abstract must be completed, including information on the reason for the resident's absence, outcome of the leave and any other pertinent information concerning the leave.~~

~~F. **Reimbursement and Billing for Reserve Bed Days**: Reimbursement for reserve bed days to the ICF-MR is limited to the provider's Level III rate. Billing for reserve bed days is based on the nursing census, which runs from midnight to midnight. Under normal circumstances, Medicaid pays for the admission day but does not pay for the discharge day. To receive payment for additional reserve bed days which require prior approval, the provider must attach a copy of the written notification of approval to the claim.~~] home and community visits, e.g., vacations; 2) to adjust to a new living environment; or 3) for hospitalizations.

A. **Coverage of reserve bed days:** Without prior authorization, medicaid covers 65 reserve bed days per calendar year for every resident for family visits, vacations, home visits, hospitalizations and adjustment to a new living environment. Reserve bed days used under this section require documentation in the facility or the client records for all absences from the facility. If the absence from the facility is not documented in the facility or the client records, medicaid will recoup the reserve bed day payment. If the resident is away from the facility with facility staff supervision, the absence is not considered a reserve bed day.

B. **Prior authorization:** After the 65 days have been expended, medicaid covers, with prior authorization, an additional six reserve bed days per calendar year for discharge planning.

(1) A resident's discharge plan must clearly state the objectives, including how visits to alternative placements relate to discharge plan implementation.

(2) To obtain medicaid prior authorization, the facility must submit the following information in writing to MAD:

(a) the resident's name;

(b) social security number;

(c) requested approval dates;

(d) copy of the discharge plan;

(e) name and address of the individual who will care for the resident; and

(f) written physician order for trial placement.

(3) Documentation of the resident's absence from the facility for these six additional reserve bed days must be in the facility or the client records.

C. **Documentation of reserve bed days:** If residents leave the ICF-MR for any reason, documentation of the absence from the facility must be in the facility or client records. Hospitalizations must be documented in the client records at the ICF-MR.

D. **Reimbursement and billing for reserve bed days:** Reimbursement for reserve bed days to the ICF-MR is limited to the provider's level III rate. Billing for reserve bed days is based on the facility census, which runs from midnight to midnight. Medicaid pays for the admission day but does not pay for the discharge day. To receive payment for the additional six reserve bed days, which require prior authorization, the provider must attach a copy of the written notification of approval by MAD to the claim.

[2-1-95; 8.313.2.20 NMAC - Rn, 8 NMAC 4. MAD.732.7 & A, 11-1-00; A, 5-1-07]

NEW MEXICO COMMISSION OF PUBLIC RECORDS

Notice of Repeal

1.18.790 NMAC, Executive Records Retention and Disposition Schedule for the Department of Public Safety, is being repealed and replaced with the new 1.18.790 NMAC, Executive Records Retention and Disposition Schedule for the Department of Public Safety, effective May 14, 2007. The New Mexico Commission of Public Records at their April 10, 2007 meeting repealed the current rules. The New Mexico Commission of Public Records at their April 10, 2007 meeting approved the new rules.

NEW MEXICO COMMISSION OF PUBLIC RECORDS

April 10, 2007

Leo R. Lucero, Agency Analysis Bureau Chief
NM Commission of Public Records
1205 Camino Carlos Rey
Santa Fe, New Mexico 87507

Mr. Lucero:

You recently requested to publish a synopsis in lieu of publishing the full content of the following rules:
* 1.18.521 NMAC ERRDS, Energy, Minerals, and Natural Resources Department,
* 1.18.550 NMAC ERRDS, Office of the State Engineer,
* 1.18.667 NMAC ERRDS, Department of Environment., and
* 1.18.790 NMAC ERRDS, Public Safety Department.

A review of the rules shows that their impact is limited to the individual agency to which it pertain, and it is "unduly cumbersome, expensive or otherwise inexpedient" to publish. Therefore, your request to publish a synopsis for it is approved.

Sincerely,

Sandra Jaramillo
State Records Administrator

SJ/lrl

NEW MEXICO COMMISSION OF PUBLIC RECORDS

SYNOPSIS
1.18.790 NMAC ERRDS, Department of Public Safety

1. Subject matter: 1.18.790 NMAC, Executive Records Retention and Disposition Schedule for the Department of Public Safety. This rule is new and replaces 1.18.790 NMAC ERRDS, Department of Public Safety an outdated re-numbered version that was filed on 6/8/2000. This records retention and disposition schedule is a timetable for the management of specif-

ic records series of the Department of Public Safety. It describes each record series by record name, record function, record content, record filing system, record confidentiality, and record retention. The record retention is the life cycle of each records series. It indicates the retention or length of time a record series must be maintained by the department as well as its final disposition. The retention and disposition requirements in this rule are based on the legal and use requirements of the records as well as on their administrative, fiscal and archival value. This rule was developed by the Records Management Division of the State Records Center and Archives (New Mexico Commission of Public Records) and approved by the State Records Administrator, the New Mexico Commission of Public Records and the Department of Public Safety.

2. Persons affected: The persons affected are the record producing and record keeping personnel of the Department of Public Safety. Persons and entities normally subject to the rules and regulations of the Department of Public Safety may also be directly or indirectly affected by this rule.

3. Interests of persons affected: Interests include the records produced and maintained by the Department of Public Safety.

4. Geographical applicability: Geographical applicability is limited to areas within the State of New Mexico covered by the Department of Public Safety. Any person or entity outside the covered geographical area that conducts business with or through the Department of Public Safety may also be affected by this rule.

5. Commercially published materials incorporated: The New Mexico Statutes Annotated 1978 were used as reference in the development of this rule. However, they do not constitute a substantial portion of this rule.

6. Telephone number and address of issuing agency: New Mexico State Records Center and Archives, 1205 Camino Carlos Rey, Santa Fe, New Mexico 87505. Telephone number: (505) 476-7900.

7. Effective date of this rule: May 14, 2007.

Certification

As counsel for the State Records Center and Archives, I certify that this synopsis provides adequate notice of the content of 1.18.790 NMAC ERRDS, Department of Public Safety.

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Alvin Garcia Date
Assistant Attorney General

NEW MEXICO COMMISSION OF PUBLIC RECORDS

This is an amendment to 1.17.230 NMAC, Section 213, effective May 14, 2007.

1.17.230.213 PRETRIAL SERVICES FILES:

A. Program: criminal matters

B. Maintenance system: chronological by calendar year, then alphabetical by defendant surname

C. Description: record of criminal pretrial services and recommendations to the court for sentencing and conditions of release. File may contain background investigation records, pretrial services supervision records, judicial supervision program records, mental health court records, drug court records, homeless court records, competency court records, jail diversion records, photograph, national criminal information check report, treatment records, psychological evaluations, etc.

D. Retention:

(1) Dismissed cases: upon dismissal of case

(2) All other cases: three calendar years from date of sentencing

E. Confidentiality: Portions of record may be confidential per Section 31-21-6 NMSA 1978 (i.e., social records, pre-sentencing reports, pre-parole reports and supervision histories, etc.), Sections 31-25-3 and 31-25-4 NMSA 1978 (i.e., safe house, abuse shelter, other shelter facility, etc.), Section 14-6-1 (i.e., all health information), 45 CFR Subpart E of Part 164, (i.e., protected health identifiers), 32A-1-17 NMSA 1978 (i.e., children's files, records and transcripts, etc.), Section 32A-2-32 NMSA 1978 (i.e., children's social records, diagnostic evaluations, medical records, supervision histories, etc.), 32A-4-33 NMSA 1978 (i.e., child neglect or abuse records), 42 CFR 2 (i.e., patient records, diagnosis, treatment, referral, etc.), etc.

[1.17.230.213 NMAC - N, 5/14/2007]

NEW MEXICO COMMISSION OF PUBLIC RECORDS

SYNOPSIS
1.18.521 NMAC ERRDS, Energy, Minerals and Natural Resources Department

1. Subject matter: 1.18.521 NMAC, Executive Records Retention and Disposition Schedule for the Energy, Minerals and Natural Resources Department. This rule is an amendment to 1.18.521 NMAC ERRDS, Energy, Minerals and Natural Resources Department filed on 8/25/2006. This records retention and disposition schedule is a timetable for the management of specific records series of the Energy, Minerals and Natural Resources Department. It describes each record series by record name, record function, record content, record filing system, record confidentiality, and record retention. The record retention is the life cycle of each records series. It indicates the retention or length of time a record series must be maintained by the Energy, Minerals and Natural Resources Department as well as its final disposition. The retention and disposition requirements in this rule are based on the legal and use requirements of the records as well as on their administrative, fiscal and archival value. This rule was developed by the Records Management Division of the State Records Center and Archives (New Mexico Commission of Public Records) and approved by the State Records Administrator, the New Mexico Commission of Public Records and the Energy, Minerals and Natural Resources Department.

2. Persons affected: The persons affected are the record producing and record keeping personnel of the Energy, Minerals and Natural Resources Department. Persons and entities normally subject to the rules and regulations of the Energy, Minerals and Natural Resources Department may also be directly or indirectly affected by this rule.

3. Interests of persons affected: Interests include the records produced and maintained by the Energy, Minerals and Natural Resources Department.

4. Geographical applicability: Geographical applicability is limited to areas within the State of New Mexico covered by the Energy, Minerals and Natural Resources Department. Any person or entity outside the covered geographical area that conducts business with or through the Energy, Minerals and Natural Resources Department may also be affected by this rule.

5. Commercially published materials incorporated: The New Mexico Statutes Annotated 1978 were used as reference in the development of this rule. However, they do not constitute a substantial portion of this

rule.

6. Telephone number and address of issuing agency: New Mexico State Records Center and Archives, 1205 Camino Carlos Rey, Santa Fe, New Mexico 87505. Telephone number: (505) 476-7900.

7. Effective date of this rule: May 14, 2007.

Certification

As counsel for the State Records Center and Archives, I certify that this synopsis provides adequate notice of the content of 1.18.521 NMAC ERRDS, Energy, Minerals and Natural Resources Department.

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Alvin Garcia Date
Assistant Attorney General

NEW MEXICO COMMISSION OF PUBLIC RECORDS

SYNOPSIS
1.18.550 NMAC ERRDS, Office of the State Engineer

1. Subject matter: 1.18.550 NMAC, Executive Records Retention and Disposition Schedule for the Office of the State Engineer. This records retention and disposition schedule is a timetable for the management of specific records series of the Office of the State Engineer. It describes each record series by record name, record function, record content, record filing system, record confidentiality, and record retention. The record retention is the life cycle of each records series. It indicates the retention or length of time a record series must be maintained by the office as well as its final disposition. The retention and disposition requirements in this rule are based on the legal and use requirements of the records as well as on their administrative, fiscal and archival value. This rule was developed by the Records Management Division of the State Records Center and Archives (New Mexico Commission of Public Records) and approved by the State Records Administrator, the New Mexico Commission of Public Records and the Office of the State Engineer.

2. Persons affected: The persons affected are the record producing and record keeping personnel of the Office of the State Engineer. Persons and entities normally subject to the rules and regulations of the Office of the State Engineer may also be directly or indirectly affected by this rule.

3. Interests of persons affected: Interests include the records produced and maintained by the Office of the State Engineer.

4. Geographical applicability: Geographical applicability is limited to areas within the State of New Mexico covered by the Office of the State Engineer. Any person or entity outside the covered geographical area that conducts business with or through the Office of the State Engineer may also be affected by this rule.

5. Commercially published materials incorporated: The New Mexico Statutes Annotated 1978 were used as reference in the development of this rule. However, they do not constitute a substantial portion of this rule.

6. Telephone number and address of issuing agency: New Mexico State Records Center and Archives, 1205 Camino Carlos Rey, Santa Fe, New Mexico 87507. Telephone number: (505) 476-7902.

7. Effective date of this rule: May 14, 2007.

Certification

As counsel for the State Records Center and Archives, I certify that this synopsis provides adequate notice of the content of 1.18.550 NMAC ERRDS, Office of the State Engineer.

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Alvin Garcia Date
Assistant Attorney General

NEW MEXICO COMMISSION OF PUBLIC RECORDS

SYNOPSIS
1.18.667 NMAC ERRDS, Department of Environment

1. Subject matter: 1.18.667 NMAC. Executive Records Retention and Disposition Schedule for the Department of Environment. This rule is a modification to the existing ERRDS, 1.18.667 NMAC, filed June 8, 2000. Sections 1.18.667.1 through 1.18.667.13 will be modified to add standard ERRDS language and re-number the first three record series. Sections 1.18.667.88, 1.18.667.89, 1.18.667.90, 1.18.215 and 1.18.216 record series were added to the existing schedule. Sections 1.18.667.91, 1.18.667.92, 1.18.667.93, 1.8.667.201. 1.18.667.202 and 1.18.206 were amended to better define the record series and change the retention of these records. Sections 1.18.667.94, 1.18.667.95, 1.18.667.96, 1.18.667.203, 1.18.667.204, 1.18.667.205, 1.18.667.211, 1.18.667.213 and 1.18.667.214 were repealed. The retention and disposition requirements on this schedule are based on the legal and use requirements of the records and on their administrative, legal, fiscal and archival values. This records retention and disposition schedule was developed by the State Records Center and Archives (New Mexico Commission of Public Records), and approved by the State Records Administrator, the Cabinet Secretary of the Department of Environment, and legal counsel for the Department of Environment.

2. Persons affected: The persons affected are the record producing and record keeping personnel of the Department of Environment. Persons and entities normally subject to the rules and regulations of the Department of Environment may also be directly or indirectly affected by this rule.

3. Interests of persons affected: Interests include the records produced and maintained by the Department of Environment.

4. Geographical applicability: Geographical applicability is limited to areas within the State of New Mexico covered by the Department of Environment. Any person or entity outside the covered geographical area that conducts business with or through the Department of Environment may also be affected by this rule.

5 Commercially published materials incorporated: The New Mexico Statutes Annotated 1978 is used as reference in the development of this rule. However, they do not constitute a substantial portion of this rule.

6. Telephone number and address of issuing agency: New Mexico State Records Center and Archives, 1205 Camino Carlos Rey, Santa Fe, New Mexico 87505. Telephone number: (505) 476-7900.

7. Effective date of this rule: May 14, 2007.

Certification

As counsel for the State Records Center and Archives, I certify that this synopsis provides adequate notice of the content of 1.18.667 NMAC ERRDS, Department of Environment.

Alvin Garcia Date
Assistant Attorney General

NEW MEXICO COMMISSION OF PUBLIC RECORDS

This is an amendment to 1.19.2 NMAC, Sections 7, 103-127, effective May 14, 2007.

1.19.2.7 DEFINITIONS:

A. "Administrator" means the state records administrator (Section 14-3-2 NMSA 1978).

B. "Archives" means the state archives of the commission of public records.

C. "Disposition" means final action that puts into effect the results of an appraisal decision for a series of records (i.e., transfer to archives or destruction).

D. "Local government records retention and disposition schedule" means rules adopted by the commission describing the records created and maintained by local government officials and establishing a timetable for their life cycle and providing authorization for their disposition.

E. "Microphotography" means the transfer of images onto film and electronic imaging or other information storage techniques that meet the performance guidelines for legal acceptance of public records produced by information system technologies pursuant to regulations adopted by the commission of public records.

F. "Non-record" means extra copies of documents kept solely for convenience of reference, stocks of publications, records not usually included within the scope of the official records of an agency or government entity, and library material intended only for reference or exhibition. The following specific types of materials are non-records: materials neither made nor received in pursuance of statutory requirements nor in connection with the functional responsibility of the officer or agency; extra copies of correspondence; preliminary drafts.

G. "Property footprints" means a perimeter sketch of property being taxed.

[G.] H. "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).

[H.] I. "Records custodian" means any public officer responsible for the maintenance, care or keeping of a public body's public records.

[I.] J. "Records management" means the systematic control of all records from creation or receipt through processing, distribution, maintenance and retrieval, to their ultimate disposition.

[J.] K. "Retention" 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.

[1.19.2.7 NMAC - N, 04/24/2006; A, 5/14/2007]

1.19.2.103 RESIDENTIAL REAL PROPERTY TRANSFER DECLARATION AFFIDAVIT:

A. Program: assessments

B. Maintenance system: local government preference

C. Description: records concerning the declaration of transfer of real property by deed or real estate contract. This is a hardcopy input document to the *valuation system*. Affidavit may include property address, sellers name and mailing address, buyer's name and mailing address, physical location of property, legal description, sales information, [~~structure type and description,~~] signature of buyer and seller, date, notary signature, etc.

D. Retention: two years from date of affidavit

E. Confidentiality: Portions of this record may be confidential per [~~Section 7-38-12 NMSA 1978~~] Subsection C of Section 7-38-12.1 NMSA 1978 (i.e., confidentiality of affidavit information).

[1.19.2.103 NMAC - N, 04/24/2006; A, 5/14/2007]

1.19.2.104 [~~NOTICE OF~~] VALUATION SYSTEM:

A. Program: assessments

B. Maintenance system: local government preference

[~~C. Description:~~ ~~system used to track the net taxable value of property. Data may include property owner's name, legal description, ownership deed information, real estate contract information, uniform property card number, location number, exemptions, type and amount of exemptions, school district, property use (residential or non-residential), physical address, owner's mailing address, valuation mailing date, notice of valuation contest, distance to street, lot dimensions, acreage, square feet of building, components of dwelling, sale price information, parcel number, etc.~~

~~D.~~ ~~Retention: permanent~~

~~E. Hardcopy input documents:~~ ~~All documents used as input for *notice of valuation system* are filed in the *notice of valuation* file. Those documents include the following: *real estate contracts, plats, deeds, mortgages, etc.*~~

~~F. Hardcopy output documents:~~ ~~Because this is a data based system, ad hoc reports may be generated upon request or demand. When produced, these reports are forwarded to the requesting entity. Some of these reports include valuation protests, etc.~~]

C. Description:

(1) Manual document system: manual document system used to track and develop taxable property valuation and result of protest hearings. Documents may include name of owner, parcel uniform number, account number, legal description, ownership information, property classification and type, school district, sales prices and sales information (contained in the residential real property transfer affidavit), cost information, income or expense information, zoning information, parcel and building information such as topography, view, lot and buildings size, street name and on-site amenities, building information (such as siding, roofing, foundation type, plot plans, ground plan sketch, property photos, etc.), etc.

(2) Automated data system: in house or external developed computer assisted mass appraisal (CAMA) system used to track and develop taxable property valuation and results of protest hearings. Data may include name of owner, parcel uniform number, account number, legal description, ownership information, property classification and type, school district, sales prices and sales information (contained in 1.19.2.103 NMAC *residential real property transfer declaration affidavit*), cost data, income or expense data, zoning information, parcel and building information such as topography, view, lot and buildings size, street name and on-site amenities, building information (such as siding, roofing, foundation type, plot plans, ground plan sketch, property photos, etc.), etc.

(3) Hybrid automated and document system: this is a combination of the automated and manual systems. Information may include name of owner, parcel uniform number, account number. Please refer to the manual document and automated systems for document and data types.

D. Retention: until superseded

E. Input: All documents

used as input for the *valuation system* are filed in the *residential real property transfer declaration affidavit*; *building permits; plats*, *surveys and maps file;* state approved valuation manuals. In addition to the hardcover copy records, data is transferred from the *property administrative system*.

F. Output: Property valuation data is transferred to (1.19.2.110 NMAC) *property administrative system* for all taxable real property (i.e., manufactured homes, commercial, industrial single family, multiple family, etc.). Because the *valuation system* is a data-based system, ad hoc and regularly scheduled reports may be generated on request or demand. When produced, these reports are forwarded to the requesting entity. Some of the reports include sales ratio study reports, valuation certification reports, parcel count by type and other property listings, etc.

G. Confidentiality: Portions of this record may be confidential per Section 7-38-4 NMSA 1978 (i.e., any information about a specific property or property owner), Section 7-38-12.1 NMSA 1978 (i.e., any input from the affidavit, "The county assessor shall retain the original affidavit as a confidential record…"), etc.

[1.19.2.104 NMAC – N, 04/24/2006; A, 5/14/2007]

[See 1.13.3 NMAC for *Management of Electronic Records*.]

1.19.2.105 NOTICE OF VALUATION [~~FILE~~]:

A. Program: assessments

B. Maintenance system: local government preference

[~~C. Description: notice issued to property owner regarding the net taxable value of property. Notice may include property owner's name, mailing address, legal description, uniform property card number, location number, property use (residential or non-residential), property value information, exemptions, type and amount of exemptions, school district, property use, location address, valuation mailing date, protest period end date, general information, address or ownership changes, owner signature, notice of valuation contest, distance to street, lot dimensions, acreage, square feet of building, components of dwelling, sale price information, parcel number, ground plan sketch, etc. Serves as input to the notice of valuation system.~~

~~D. Retention:~~ ~~permanent~~

~~E. Confidentiality:~~ ~~Portions of this record may be confidential per Section 7-38-4 NMSA (i.e., confidentiality of information, violations by department employees).~~]

C. Description: notice issued annually to inform property owners of their property taxable value and status of their property. This may be hardcover output from (1.19.2.104 NMAC) *valuation system*. File may include notice (i.e., ownership, mailing and physical addresses, uniform parcel codes, account number, property classification and types, exempts granted and amounts, legal descriptions, assessed and table values, taxable ratio, remedies for protesting values), exemption application form, agricultural request form, address change form, etc.

D. Retention: 10 years after the end of the calendar year in which notice issued

[1.19.2.105 NMAC - Rp, 1.19.2.105 NMAC, 04/24/2006; A, 5/14/2007]

[For historical information refer to 1.19.2.106 NMAC *tax schedule*.]

1.19.2.106 TAX SCHEDULE:

A. Program: assessments

B. Maintenance system: local government preference

C. Description: record of annual assessment and valuation on declared property, within the school district, by the tax assessor. Schedule may include [~~tax certificate~~] state assessed information, [~~and~~] tax rates, taxes due, taxable ratio, allocation of net taxable values to appropriate governmental units, property classification and type property owner, mailing and physical addresses, legal description, exemptions types and amounts, assessed and taxable values, etc.

D. Retention: permanent

[1.19.2.106 NMAC - Rp, 1.19.2.106 NMAC, 04/24/2006; A, 5/14/2007]

[See 1.13.3 NMAC for *Management of Electronic Records* regarding the maintenance of long term or permanent electronic records. In an automated *valuation system* or *property administrative system* an annual hardcover copy tax schedule shall be printed out for historical purposes.]

1.19.2.107 G E O G R A P H I C INFORMATION SYSTEM (GIS):

A. Program: assessments

B. Maintenance system: local government preference

C. Description: system used to track geographical parcel information on properties being taxed. Data may include aerial photographs, [~~valuation information, township number, range number, section number, school district code, commercial or residential property, area section, parcel map, uniform parcel code, lot splits, lot consolidations and subdivisions~~] contour lines, street easements, utilities locations, property footprints, legal descriptions, parcel and building characteristics, etc.

D. Data retention: [~~per manent~~] until superseded

E. [~~Hardcopy input documents:~~ ~~All documents used as input for *geographic information system* are filed in the *notice of valuation* file, *tax schedule*, *valuation protest* file. Those documents include: *plats*, *deeds*, *mortgages*, *tax schedule, exemption forms, valuation protest* form, etc.~~] **Input:** All information used as input for *geographic information system* includes (1.19.2.104 NMAC) *valuation system*, (1.19.2.113 NMAC) *plats, surveys and maps file*, (1.19.3.102 NMAC) deeds, (1.19.2.109 NMAC) *property record card*, (1.19.2.103 NMAC) *residential real property transfer declaration affidavit*, (1.19.2.114 NMAC) *assessment maps*, etc.

F. [~~Hardcopy output documents:~~ ~~Because this~~] **Output:** Because the *geographic information system* is a data-based system, ad hoc and regularly scheduled reports may be generated upon request or demand. When produced, these reports are forwarded to the requesting entity. Some of these reports include deeds, valuation protests, plats, *assessment maps*, etc.

[1.19.2.107 NMAC – N, 04/24/2006; A, 5/14/2007]

[The parcel information layer that the assessor develops is shared with other entities which in turn produce various layers on *geographic information system* to suit their individual purposes or requirements and the assessor is not responsible for those layers. See 1.13.3 NMAC for *Management of Electronic Records*.]

1.19.2.108 CERTIFICATE OF CORPORATE PROPERTY:

A. Program: assessments

B. Maintenance system: local government preference

C. Description: certificate issued by state property tax division to county assessors regarding valuation properties that do business in multiple counties. Certificate may include school district number, properties owned, assets, name of business, legal descriptions (i.e., township number, section number, range number, subdivision), etc.

D. Retention: 10 years after close of fiscal year in which [~~created~~] certificate issued

[1.19.2.108 NMAC - Rp, 1.19.2.108 NMAC, 04/24/2006; A, 5/14/2007]

1.19.2.109 P R O P E R T Y RECORD CARD:

A. Program: assessment

B. Maintenance system: local government preference

C. Description: record used to track and develop taxable property valuations. In an automated *valuation sys-*

tem this is a hardcover output document. The property record card includes name of owner, uniform parcel number, account number, legal description of property, property classification and type, school district number, zoning information, parcel and building descriptions (such as topography, view, lot and buildings size, street, on-site amenities, etc.), building characteristics (such as siding, roofing, foundation type, plot plans, ground plan sketch, property photos, etc.) etc.

D. Retention: 25 years after created

E. Confidentiality: Portions of this record may be confidential per Section 7-38-4 NMSA (i.e., any information about a specific property or property owner).

[1.19.2.109 NMAC - N, 5/14/2007]

[See 1.13.3 NMAC for *Management of Electronic Records* regarding the maintenance of long term or permanent electronic records.]

1.19.2.110 PROPERTY ADMINISTRATIVE SYSTEM:

A. Program: assessments

B. Maintenance system: local government preference

C. Description: system used to track tax assessments on property. Parcel data may include property owner's name, mailing and physical addresses, legal description of property, account number, ownership documents information, uniform parcel number, tax rates, location number, exemption types and amounts, school district numbers, annexations, property classification (residential or non-residential), valuation mailing date, agricultural status, property type (single family, manufactured home, multi-family, commercial, industrial, agricultural, state assessed, etc.), business personal property reports, etc.

D. Data retention: until superseded

E. Confidentiality: Portions of this record may be confidential per Subsection C of Section 7-38-12.1 NMSA 1978 (i.e., confidentiality of affidavit information).

F. Input: All records used as input for the *property administrative system* include *residential real property transfer declaration affidavit*; request for exemption forms; application form for valuation as agricultural land; grazing land carrying capacity and livestock certificate; taxpayer information; ownership documents (deeds, contracts, etc.); plats; maps; state information; business personal property reports; annexations; etc.

G. Output: Because the *property administrative system* is a data-based system, ad hoc and regularly scheduled reports or forms may be generated upon request or demand. When produced, these reports are forwarded to the requesting and statutory required entity. Portions of the parcel information serve as input to the *valuation system*. Some of these reports or forms include *notice of valuation*, *tax schedule*, abstracts, warrants, ownership listings, etc.

[1.19.2.110 NMAC - N, 5/14/2007]

[See 1.13.3 NMAC for *Management of Electronic Records*.]

1.19.2.111 COUNTY ASSESSOR PROPERTY VALUATION MANUALS:

A. Program: assessment

B. Maintenance system: local government preference

C. Description: manuals issued or approved by the property tax division to the county assessor offices for assessment purposes. Types of manuals include legal, agricultural, land, residential, mobile home, mapping and commercial.

D. Retention: until superseded or obsolete

[1.19.2.111 NMAC - N, 5/14/2007]

1.19.2.112 [~~CHANGE ORDER AND AUTHORIZATION FORM:~~] TAX SCHEDULE CORRECTION REQUEST FORM:

A. Program: assessments

B. Maintenance system: local government preference

C. Description: form used to authorize corrections to [~~notice of valuation~~] the tax schedule. Approved forms may serve as input to the *property administrative system*. Form may include taxpayer name, tax district, address, property description, uniform parcel and tax identification number, tax year, old value, new value, old taxes charged, tax rate, taxes due, net change, first half amount, second half amount, [~~comments,~~] assessor's authorization signature, treasurer's authorization signature, date, clerk name, reason for authorization request (omitted, corrected, canceled), etc.

D. Retention: three years after date of authorization or rejection

[1.19.2.112 NMAC - Rp, 1.19.2.112 NMAC, 04/24/2006; A, 5/14/2007]

1.19.2.113 PLATS, SURVEYS AND MAPS FILE:

A. Program: assessments

B. Maintenance system: local government preference

C. Description: [~~records concerning~~] plats, surveys, or maps [~~of property used~~] illustrating property boundaries for tax purposes. Portions of this file may serve as input to the *property administrative system*. File may include information contained on plats (lot and [~~square number~~] streets names, sketch of the layout of the lot), surveys (mapping the boundaries and improvements of land), maps (legal land parcel and property boundaries), etc.

D. Retention: [~~permanent~~] original document filed in county clerk's office (1.19.3.102 NMAC) *document and instrument file*

[1.19.2.113 NMAC - Rp, 1.19.2.113 NMAC, 04/24/2006; A, 5/14/2007]

1.19.2.114 ASSESSMENT MAPS:

A. Program: assessments

B. Maintenance system: local government preference

C. Description: maps used to determine assessment value of property located within [~~one adjacent square mile of township, range and section number~~] taxing jurisdiction. This may be a hardcover output document from the *geographic information system (GIS)*. Map may include lot number, name of subdivision, size, legal description, meets and bounds, drawing improvements, tax code, etc.

D. Retention: [~~permanent~~] until superseded or obsolete

[1.19.2.114 NMAC - Rp, 1.19.2.114 NMAC, 04/24/2006; A, 5/14/2007]

1.19.2.115 SALES RATIO STUDY LOG:

A. Program: assessments

B. Maintenance system: local government preference

C. Description: annual record of property sales figures used to determine property market value. Portions of this document may serve as input to the *valuation system*. Log may include property description and location, net taxable value, full value, property type, etc.

D. Retention: five years after study completed

[1.19.2.115 NMAC - Rp, 1.19.2.115 NMAC, 04/24/2006; A, 5/14/2007]

1.19.2.116 BUILDING PERMITS:

A. Program: assessments

B. Maintenance system: local government preference

C. Description: copies of building permits issued by state tradeboards, county planning and municipalities. Permit may include building address, date issued, permit number, description of work (i.e., new construction, addition, alteration - repair or demolition), owner's name, contractor's name, etc.

D. Retention: until purpose is served

[1.19.2.116 NMAC - N, 5/14/2007]

1.19.2.117 WATER IRRIGA-

TION DISTRICT ASSESSMENT LIST:

A. Program: assessments

B. Maintenance system: local government preference

C. Description: a certified annual assessment list of members of water systems within the county. List may include members name, district number, location, etc.

D. Retention: one year after the end of the calendar year in which list issued

[1.19.2.117 NMAC - N, 5/14/2007]

1.19.2.118 NON GOVERNMENTAL CLAIM FOR EXEMPTION FORM:

A. Program: assessments

B. Maintenance system: local government preference

C. Description: form used by non-governmental entities to apply for tax exempt status for non-governmental use of property. Portions of this document may be input to the *property administrative system*. Form may include name of property owner, address, property description, primary use of property (educational, charitable, urban renewal property, municipal property, church property not used for commercial purposes, [~~if exemption has been authorized under a ruling or order in force of the department or a ruling of the predecessor property appraisal department), oath of affirmation, file number, etc. issued subsequent to~~] state of New Mexico property, federal property etc.), any other data necessary to determine eligibility for the exemption.

D. Retention: one year after property use changes [~~or~~], ownership changes or denial of claim

[1.19.2.118 NMAC - N, 04/24/2006; A, 5/14/2007]

1.19.2.119 [~~TAX EXEMPTION FORM~~] REQUEST FOR EXEMPTION FILES:

A. Program: assessments

B. Maintenance system: local government preference

C. Description: form used to apply for tax exemption by [~~military, low income households, persons with disabilities, head of household, or age sixty five or older property owners who are applying for the tax exempt status. Form may include name of property owner, address, property description, social security number, military service number, location of property, signature, notarized signature of county assessor, county name, tax year, driver's license number, date of birth, physical address, legal description of property, uniform property code number, income received, valuation limitation, certification by property owner, signature of county assessor, approved or denied status~~] veterans (regular and one hundred percent disabled), low income households, persons with disabilities, head of household, or property owners age sixty five or older property owners who are applying for the tax exempt status. Portions of this file may serve as input into the into the *property administrative system*. File may include exemption forms on regular veterans, veterans with one hundred percent disabled, low income households, persons with disabilities, head of household, or property owners age sixty five or older, correspondence, etc.

D. Retention:

(1) Veterans and property owners over 65 exemptions: until change of ownership

(2) All others: one year from date of application

[~~**E. Confidentiality:** Portions of this record may be confidential per 5 USC Section 552a (i.e., social security number).~~]

[1.19.2.119 NMAC - Rp, 1.19.2.119 NMAC, 04/24/2006; A, 5/14/2007]

[Veterans, one hundred percent disabled veterans and head of household exemptions claims are combined with the *notice of valuation*.]

1.19.2.120 [~~LIVESTOCK OWNERS AND AGRICULTURAL ACRES~~] GRAZING LAND CARRYING CAPACITY AND LIVESTOCK VALUES CERTIFICATE:

A. Program: assessments

B. Maintenance system: local government preference

[~~**C. Description:** certificate concerning all livestock and acres farmed that are valued for property taxation purposes. Certificate may include type of livestock, number of livestock (commercial and registered), number of months grazed annually, livestock identification number, livestock code, owner's name address and telephone number, assessor's real property location identification number, owner signature, property account numbers, total acreage farmed, crops grown, irrigated farming, dryland farming, crops sold, number of acres grazed, number of agricultural acres farmed, date livestock shipped, inspector name, etc.~~

~~**D. Retention:**~~

~~**(1) Paid:** one year after taxes paid~~

~~**(2) Unpaid:** ten years from date taxes due~~]

C. Description: certificate concerning all livestock types and values to include animal units per section. Certificate may include type of livestock, number of livestock per section (commercial and registered), market and taxable value for commercial and registered, grazing land capacity, etc.

D. Retention: one year after the close of the calendar year in which taxes are paid

[1.19.2.120 NMAC - Rp, 1.19.2.120 NMAC, 04/24/2006, A, 5/14/2007]

[Grazing valuation requires proof of the presence of livestock on the property and proof that the livestock has access to all of the agricultural land for the tax year. This may be in the form of a grazing lease, a personal property declaration of livestock which graze on the land or some other proof of grazing use.]

1.19.2.121 MANUFACTURED HOME VALUATION SYSTEM:

A. Program: assessments

B. Maintenance system: local government preference

C. Description: [~~system used to track history of manufactured homes located within county boundaries. Log may include owners name, address, make, model, and year of manufactured home; vehicle identification number; location, tax releases; valuation calculations; registration; *manufactured home assessment* form; *notification of no tax liability* form; *real property request for tax year* form; etc.~~] system used to track the valuation of manufactured homes located within county boundaries. Data may include name of owner; address; make, model and year of manufactured home; vehicle identification number, location, tax releases, New Mexico manufactured home appraisal worksheet or other valuation service (such as Marshall Swift, etc.), manufactured home assessment, notification of no tax liability, real property request for tax year, etc.

D. Retention: 10 years from date of motor vehicle registration

E. [~~Hardcopy~~] Input [~~documents~~]: All documents used as input for manufactured home system are filed in the *manufactured home file*. Those documents include: *manufactured home assessment* form; *notification of no tax liability* form; *real property request for tax year form*; etc.

F. [~~Hardcopy~~] Output [~~documents~~]: Because this is a data-based system, ad hoc reports may be generated upon request or demand. When produced, these reports are forwarded to the requesting entity.

[1.19.2.121 NMAC - N, 04/24/2006; A, 5/14/2007]

[This system may be electronic and part of the *valuation system* or a manual produced system utilizing the New Mexico county assessor's manufactured housing manual. See 1.13.3 NMAC for *Management of*

Electronic Records.]

1.19.2.122 MANUFACTURED HOME FILE:

A. Program: assessments

B. Maintenance system: local government preference

C. Description: record concerning the history of manufactured homes located within county boundaries. Portions of this file may be part of the *valuation system* or *property record card*. File may include owner's name, address; make, model, and year of manufactured home; vehicle identification number; location, tax releases; valuation calculations; registration; *manufactured home assessment* form; *notification of no tax liability* form; *real property request for tax year* form; etc.

D. Retention: 10 years from date of motor vehicle registration

[1.19.2.122 NMAC - Rp, 1.19.2.122 NMAC, 04/24/2006; A, 5/14/2007]

1.19.2.123 VALUATION PROTEST FILE:

A. Program: assessments

B. Maintenance system: local government preference

C. Description: [~~records protest of tax valuation by property or business owners. File may include the *business personal property valuation protest* form (protest number, account number, name of business, legal address, name of authorized agent, owner signature, hearing date, hearing time, lost of personal property, reason for protest, assessor's value, owner's value, difference of protested value, withdrawal information), *county valuation protest* form (protest number, hearing date, hearing time, name of owner, property description or legal address, mailing address, telephone number, name of authorized agent, signature of owner, account number, reason for protest, withdrawal, adjusted value, final decision, department authorization, name of business, legal address, tangible personal property, assessor's value, difference of protested amount), *vacant land comparable* form (uniform parcel code, owners name, legal address, property data, subject, sale number one, sale number two, sale number three, notes), etc.~~] records concerning the protest of property valuation by property or business owners. This is a hardcopy input document to the valuation system. File may include the *county valuation protest* form (protest number, account number, name of owner, legal address, name of authorized agent, owner signature, hearing date, hearing time, property description, mailing address, telephone number, reason for protest, assessor's value, owner's value, sales data, difference of protested value, withdrawal information, stipulated value, if any), notes, etc.

D. Retention: [~~one year from date of protest~~] 10 years after final decision

[1.19.2.123 NMAC - Rp, 1.19.2.123 NMAC, 04/24/2006; A, 5/14/2007]

1.19.2.124 APPLICATION FORM FOR VALUATION AS AGRICULTURAL LAND:

A. Program: assessment

B. Maintenance system: local government preference

C. Description: application form for valuation land used for agricultural purposes. Form may include name of property owner, address, property description, use of the land on the preceding year, total acreage farmed, crops grown, irrigated farming, dryland farming, crops sold, number of acres grazed, number of agricultural acres farmed, whether land was used for speculative use such as subdivision, any commercial or any other non-agricultural use, land lease status, and any farm income and expense data supplied to the United States internal revenue service.

D. Retention: two years after end of calendar year from date of application

[1.19.2.124 NMAC - N, 5/14/2007]

1.19.2.125 VETERANS EXEMPTION LIST:

A. Program: assessment

B. Maintenance system: local government preference

C. Description: an annual listing of veterans who have claimed their property tax exemption. List may include calendar year, veteran's name, address, status, etc.

D. Retention: one year after the end of the calendar year

[1.19.2.125 NMAC - N, 5/14/2007]

1.19.2.126 CERTIFICATE OF LIVESTOCK INSPECTION:

A. Program: assessment

B. Maintenance system: local government preference

C. Description: records concerning the inspection of livestock in collation to the assessment of property. Certificate may contain owner's name and address, transporter, date, inspector, livestock type, location, total livestock shipment, etc.

D. Retention: until livestock taxes are paid but no longer than 10 years after the end of the calendar year of assessment

[1.19.2.126 NMAC - N, 5/14/2007]

1.19.2.127 STATEMENT OF DECREASE IN VALUE OF PROPERTY SUBJECT TO LOCAL VALUATION:

A. Program: assessment

B. Maintenance system: local government preference

C. Description: statement from property owners that claim their property has decreased in valuation from the previous year. Portions of this record serves as input to the *valuation system*. Statement includes the cause and nature of the decrease in value and the amount the owner contends the valuation of his property has decreased, review actions, notes, signature of property owners and county assessor, etc.

D. Retention: two years after the end of the calendar year of decrease in value

[1.19.2.127 NMAC - N, 5/14/2007]

NEW MEXICO PUBLIC REGULATION COMMISSION

INSURANCE DIVISION

This is an amendment to 13.10.13 NMAC Sections 1, 5, 7, 9, 11, 13, 14, 15, 16, 19, 20, 25, 29, and 30, effective 4/30/2007. In accordance with the current NMAC requirements, this rule was also renumbered and reformatted from 13 NMAC 10.13 (filed 02/14/1997), "Managed Health Care" to 13.10.13 NMAC, "Managed Health Care", effective 4/30/2007.

13.10.13.1 ISSUING AGENCY: New Mexico [~~State Corporation Commission~~] Public Regulation Commission, [~~Department~~] Division of Insurance, Post Office Box 1269, Santa Fe, New Mexico 87504-1269.

[3/16/97; 13.10.13.1 NMAC - Rn & A, 13 NMAC 10.13.1, 4/30/2007]

13.10.13.5 EFFECTIVE DATE: March 16, 1997, unless a later date is cited at the end of a section[~~or paragraph~~].

[3/16/97; 13.10.13.5 NMAC - Rn & A, 13 NMAC 10.13.5, 4/30/2007]

13.10.13.7 DEFINITIONS: [~~For the purposes of this rule:~~]

A. "**Certified nurse-midwife**" means any person who is licensed by the board of nursing as a registered nurse and who is licensed by the New Mexico department of health as a certified nurse-midwife.

B. "**Certified nurse practitioner**" means a registered nurse whose qualifications are endorsed by the board of nursing for expanded practice as a certified nurse practitioner and whose name and pertinent information is entered on the list of certified nurse practitioners maintained by the board of nursing.

C. "**Continuous quality**

improvement" means an ongoing and systematic effort to measure, evaluate, and improve a managed health care plan's process in order to continually improve the quality of health care services provided to its enrollees.

D. "**Cytologic screening**" means a papanicolaou test and a pelvic exam for symptomatic as well as asymptomatic female patients.

E. [~~"Department"~~] "**Division**" means the New Mexico [~~Department~~] division of insurance.

F. "**Emergency care**" means health care procedures, treatments, or services delivered to a covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson, to result in:

(1) jeopardy to the person's health;

(2) serious impairment of bodily functions;

(3) serious dysfunction of any bodily organ or part; or

(4) disfigurement to the person.

G. "**Enrollee**" means any individual who is entitled to receive health care benefits provided by a managed health care plan.

H. "**Evidence of coverage**" means a clear and conspicuous written statement of the essential features and medical services covered by the managed health care plan and which is given to the enrollee or subscriber by the managed health care plan, by the health care insurer, or by a group contract holder.

I. "**FDA**" means the United States food and drug administration.

J. "**Grievance**" means a written complaint submitted by or on behalf of an enrollee regarding any aspect of the MHCP's health care services, including but not limited to the:

(1) availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(2) administrative practices of the health care insurer that affect the availability, delivery or quality of health care services;

(3) claims payment, handling or reimbursement for health care services; or

(4) matters pertaining to the contractual relationship between an enrollee or subscriber and a health care insurer.

K. "**Health care facility**" means an institution providing health care services, including a hospital or other licensed inpatient center; an ambulatory surgical or treatment center; a skilled nursing center; a residential treatment center; a home health agency; a diagnostic, laboratory or imaging center; and a rehabilitation or other therapeutic health setting.

L. "**Health care insurer**" means a person that has a valid certificate of authority in good standing under the Insurance Code to act as an insurer, health maintenance organization, nonprofit health care plan or prepaid dental plan.

M. "**Health care professional**" means a physician or other health care practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide health care services consistent with state law.

N. "**Health care services**" includes, to the extent offered by the plan, physical health or community-based mental health or developmental disability services, including services for developmental delay.

O. "**Health maintenance or**ganization" means any person who undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles.

P. "**Independent quality review organization (IQRO)**" means an organization independent of the health care insurer or managed health care plan that performs external quality audits of managed health care plans and submits reports of its findings to both the managed health care plan and to the [~~Department~~] division.

Q. [~~"Independent utilization review board (IURB)" means a board independent of the health care insurer or managed health care plan and appointed by the superintendent, consisting of two physicians and one attorney, all of whom are duly licensed in the state of New Mexico, who will hear utilization management grievances as outlined in 13 NMAC 10.13.15.18.~~] [RESERVED]

R. "**Managed care**" means a system or technique(s) generally used by third party payors or their agents to affect access to and control payment for health care services. Managed care techniques most often include one or more of the following:

(1) prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or site of services;

(2) contracts with selected health care providers;

(3) financial incentives or disincentives for enrollees to use specific providers, services, or service sites;

(4) controlled access to and coordination of services by a case manager; and

(5) payor efforts to identify treatment alternatives and modify benefit restrictions for high cost patient care.

S. "**Managed health care plan (MHCP or plan)**" means a health care insurer or a provider service network when offering a benefit that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health care insurer or provider service network. "Managed health care plan" or "plan" does not include a health care insurer or provider service network offering a traditional fee-for-service indemnity benefit or a benefit that covers only short-term travel, accident-only, limited benefit, student health plan or specified disease policies.

T. "**Medical necessity or medically necessary**" means appropriate or necessary services as determined by a participating provider affiliated with the managed health care plan, in consultation with the MHCP, which are rendered to an enrollee for any covered condition requiring, according to generally accepted principles of good medical practice, the diagnosis or direct care and treatment of an illness, injury, or medical condition, and are not services provided only as a convenience.

U. "**Obstetrician-gynecologist**" means a physician who is board eligible or board certified by the American board of obstetricians and gynecologists or by the American college of osteopathic obstetricians and gynecologists.

V. "**Participating provider**" means a provider who, under a contract (or through other arrangement) with the health care insurer offering a managed health care plan, or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than copayments or deductibles, directly or indirectly from the managed health care plan or health care insurer.

W. "**Physician assistant**" means a skilled person who is a graduate of a physician assistant or surgeon assistant program approved by a nationally recognized accreditation body or who is currently certified by the national commission on certification of physician assistants, and who is licensed in the state of New Mexico to practice medicine under the supervision of a licensed physician.

X. "**Primary care physician (PCP)**" means a physician who supervises, coordinates, and provides initial and basic care to enrollees, who initiates their referral for specialist care, and who maintains continuity of patient care. Primary care physicians shall include but not be limited to general practitioners, family practice

physicians, internists, pediatricians, and obstetricians-gynecologists. Pursuant to Paragraph (2) of Subsection A of 13.10.13.9 NMAC, other health care professionals may also provide primary care.

Y. "**Prospective enrollee**" means:

(1) in the case of an individual who is a member of a group, an individual eligible for enrollment in a MHCP through that individuals group; or

(2) in the case of an individual who is not a member of a group or whose group has not purchased or does not intend to buy a MHCP, an individual who has expressed an interest in purchasing individual plan coverage and is eligible for coverage by the plan.

Z. "**Provider**" means a duly licensed hospital, physician, or other health professional authorized to furnish health services within the scope of his or her license.

AA. "**Registered lay midwife**" means any person who practices lay midwifery and is registered as a lay midwife by the New Mexico department of health.

BB. "**Screening mammography**" means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic persons and includes the x-ray examination of the breast using equipment that is specifically for mammography, including the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. Screening mammography includes two views for each breast. Screening mammography includes the professional interpretation of the film, but does not include diagnostic mammography.

CC. "**Subscriber**" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the managed health care plan, or in the case of an individual contract, the person in whose name the contract is issued.

DD. "**Tertiary care facility**" means a hospital unit which provides complete perinatal care and intensive care of intrapartum and perinatal high-risk patients with responsibilities for coordination of transport, communication, education and data analysis systems for the geographic area served.

EE. "**Urgent care**" means medically necessary health care services provided in emergencies or after a primary care physician's normal business hours for unforeseen conditions due to illness or injury that are not life-threatening but require prompt medical attention.

FF. "**Utilization review**" means a system for reviewing the appropriate and efficient allocation of medical services and hospital resources given or proposed to be given to a patient or group of patients.

[3/16/97, 6/30/98, 12/1/98; 13.10.13.7 NMAC - Rn & A, 13 NMAC 10.13.7, 4/30/2007]

13.10.13.9 BASIC HEALTH CARE SERVICES: A health care insurer offering comprehensive basic health care services through its managed health care plan shall provide or shall arrange for the following basic health care services and medically necessary health care services for its enrollees.

A. **Physician services**:

(1) Physician services are those services that are reasonably required to maintain good health, including, but not limited to, periodic examinations and office visits with a primary care physician, specialist and referral services provided by a licensed physician, and services provided by other health professionals who are licensed to practice, are certified, and are practicing under authority of the managed health care plan, a medical group, an independent practice association, or other authority authorized by applicable New Mexico law.

(2) Nothing contained in this section or contained in the definition of "primary care physician" shall preclude other health care professionals such as doctors of oriental medicine, chiropractic physicians, nurse practitioners, physician assistants, or certified nurse midwives from providing primary care, provided that the health care professional: 1) is acting within his or her scope of practice as defined under the relevant state licensing law; 2) meets the MHCP eligibility criteria for health care professionals who provide primary care; and 3) agrees to participate and to comply with the health care insurers or MHCPs care coordination and referral policies.

B. **Outpatient medical services**: Outpatient medical services shall include those hospital services that can reasonably be provided on an ambulatory basis, and those preventative, medically necessary, and diagnostic and treatment procedures that are prescribed by an enrollee's primary care or attending physician. Such services may be provided at a hospital, a physician's office, any other appropriate licensed facility, or at any other appropriate facility if the professional delivering the services is licensed to practice, is certified, and is practicing under authority of the health care insurer or MHCP, a medical group, an independent practice association or other authority authorized by applicable New Mexico law.

C. **Inpatient hospital services**: Inpatient hospital services shall include, but not be limited to, semi-private room accommodations, general nursing care, meals and special diets or parenteral nutrition when medically necessary, physician and surgeon services, use of all hospital facilities when use of such facilities is determined to be medically necessary by the enrollee's primary care physician or treating physician, pharmaceuticals and other medications, anesthesia and oxygen services, special duty nursing when medically necessary, radiation therapy, inhalation therapy, and administration of whole blood and blood components when medically necessary.

D. **Emergency and urgent care services**: Emergency and urgent care services shall include:

(1) Acute medical care that is available twenty-four hours per day, seven days per week, so that jeopardy to an enrollee's health status that would occur if such services were not received immediately is prevented. Such medical care shall include ambulance or other emergency transportation. In addition, acute medical care shall include, where appropriate, transportation and indemnity payments or service agreements for out of service area or out of network coverage in cases where the enrollee cannot reasonably access in-network services or facilities; and

(2) Coverage for trauma services at any designated level I, level II, or other appropriately designated trauma center according to established emergency medical services triage and transportation protocols. Coverage for trauma services and all other emergency services shall continue at least until the enrollee is medically stable, does not require critical care, and can be safely transferred to another facility based on the judgment of the attending physician in consultation with the MHCP. If the health care insurer or managed health care plan requests transfer to a hospital participating in its provider network, the patient must be stabilized and the transfer effected in accordance with federal law. See 42 CFR 489.20 and 42 CFR 489.24.

(3) Reimbursement for emergency care and emergency transportation shall not be denied by the health care insurer or MHCP when the enrollee, who in good faith and who possesses average knowledge of health and medicine, seeks medical care for what reasonably appears to the enrollee to be an acute condition that requires immediate medical attention, even if the patient's condition is subsequently determined to be non-emergent.

(4) In determining whether the "reasonable layperson" standard as outlined in Paragraph (3) of Subsection D of 13.10.13.9 NMAC is met and whether care is reimbursable as emergency care, the MHCP shall take the following factors into consideration:

(a) a reasonable person's belief that the circumstances required immediate medical care that could not wait until the next working day or next available appointment;

(b) the time of day the care was provided;

(c) the presenting symptoms; and

(d) any circumstances which precluded use of the MHCP's established procedures for obtaining emergency care.

(5) Reimbursement for emergency care shall not be denied in those instances when the enrollee is referred to emergency care by the enrollee's primary care physician or by the MHCP.

(6) No prior authorization shall be required for emergency care. In addition, appropriate out-of-network emergency care shall be provided to an enrollee without additional cost. Whether out-of-network emergency care is appropriate shall be determined by the reasonable layperson standard contained in [~~13 NMAC 10.13.9.4.5~~] Paragraph (4) of Subsection D of 13.10.13.9 NMAC.

E. **Short-term rehabilitation services and physical therapy**: Short-term rehabilitation services and physical therapy shall be provided in those instances where the enrollee's primary care physician or other appropriate treating physician determines that such services and therapy can be expected to result in the significant improvement of an enrollee's physical condition within a period of two months. Such services may be extended beyond the two month period upon recommendation by the primary care physician in consultation with the MHCP.

F. **Children's health care**. Children's health care shall include, but not be limited to:

(1) immunizations in accordance with recommendations of the American academy of pediatrics;

(2) vision and hearing testing for persons through age 17 to determine the need for vision and hearing corrections;

(3) well-child care from birth in accordance with recommendations of the American academy of pediatrics;

(4) prenatal care, including medically necessary nutritional supplements prescribed by the expectant mother's obstetrician-gynecologist, or other physician from whom the expectant mother is receiving prenatal care, if maternity coverage is provided by the MHCP;

(5) availability of educational materials or consultation from providers to discuss lifestyle behaviors that promote health and well-being including, but not limited to, the consequences of tobacco use, nutrition and diet recommendations, exercise plans, and, as deemed appropriate by the primary care physician or as requested by the parents or legal guardian, educational information on alcohol and substance abuse, sexually-transmitted diseases, and contraception;

(6) the provisions of Sections 59A-22-34, 59A-22-34.1, 59A-23B-10.2, 59A-46-37, and 59A-46-38 NMSA 1978 shall apply to all health care policies and plans, including managed health care policies and plans issued in this state.

G. **Women's health care**: Women's health care coverage shall include, at a minimum, the following services.

(1) Each MHCP shall provide coverage for low-dose screening mammograms for determining the presence of breast cancer, in accordance with the requirements set out in the New Mexico Insurance Code. Only equipment designed specifically to perform low-dose mammography in imaging facilities that have met American college of radiology accreditation standards for mammography shall be used when a mammogram is performed. Coverage for mammograms may be subject to reasonable copayments, co-insurance, and deductibles consistent with those imposed on other benefits under the same managed health care plan, contract, or policy.

(2) MHCPs that provide mastectomy coverage as either a basic or supplemental health care service must also cover mammography for screening and diagnostic purposes, prosthetic devices, and reconstructive surgery.

(3) Each MHCP shall provide coverage for cytologic screening to detect the presence of precancerous or cancerous conditions and health problems; such cytologic screening shall be made available in accordance with the requirements set out in the New Mexico Insurance Code. Coverage for cytologic screening may be subject to reasonable copayments, co-insurance and deductibles consistent with those imposed on other benefits under the same managed health care contract, plan, or policy.

(4) Pursuant to Sections 59A-22-35 and 59A-46-39 NMSA 1978, each MHCP that provides maternity coverage shall also provide, when necessary to protect the life of the infant, the mother, or both, coverage for transportation, including air transport, for the medically high-risk pregnant woman with an impending delivery of a potentially viable infant to the nearest available tertiary care facility.

(5) Each MHCP which provides maternity coverage shall also provide coverage as required by 13.10.2 NMAC.

(6) Each MHCP shall provide coverage for services related to the diagnosis, treatment, and appropriate management of osteoporosis when such services are determined to be medically necessary by an enrollee's primary care physician in consultation with the MHCP.

(7) Each MHCP that provides coverage for reproductive health or gynecological care and which is issued, delivered, issued for delivery, or renewed in this state on or after July 1, 1997, shall permit female enrollees age 13 or older direct access to obstetric and gynecological care by:

(a) including qualified women's health care providers as eligible primary care physicians, provided that they meet the MHCP's eligibility criteria for all specialists seeking primary care physician status, have agreed to participate and to comply with the health care insurer's or plan's care coordination and referral policies;

(b) allowing female enrollees to select as their primary care physician any in-network, participating women's health care provider of the enrollee's choice; and

(c) allowing female enrollees who have not chosen a women's health care provider as their PCP to self-refer, without requiring prior authorization or pre-approval from the plan or their primary care physician, to an in-network, participating women's health care provider of the enrollee's choice for any gynecological examination or care related to pregnancy, and, subject to the limitations listed in Paragraph (13) of Subsection G of 13.10.13.9 NMAC, for primary and preventative obstetric and gynecological services required as a result of any gynecological examination or condition;

(d) nothing in this subsection shall prohibit a MHCP from allowing a female enrollee to have both a primary care physician and a women's health care provider as the female enrollee's primary care physicians.

(8) The services for which an enrollee may self-refer are limited to those services defined by the published recommendations of the accreditation council for graduate medical education for training as an obstetrician or gynecologist. The MHCP may require the women's health care provider to discuss with the female enrollee's primary care physician any services or treatment the women's health care provider recommends for the enrollee. The women's health care provider must comply with the MHCP's coordination and referral policies.

(9) As used in this section, "women's health care providers" means obstetricians-gynecologists, family practitioners, certified nurse-midwives, other physicians specializing in women's health, and physician assistants or certified nurse practitioners specializing in women's

health. A MHCP may also make registered lay midwives available to female enrollees for prenatal care and delivery. The MHCP may assure that those providers who seek to provide the services described in Paragraph (8) of Subsection G of 13.10.13.9 NMAC who are not obstetricians-gynecologists or who are not practicing under the supervision of obstetricians-gynecologists have the requisite background, training, and experience to properly examine and treat self-referred female enrollees.

(10) A female enrollee who has as her primary care physician someone other than a women's health care provider shall be allowed direct access to an in-network, participating women's health care provider of her choice for any gynecological examination or care related to pregnancy, and for primary and preventative obstetric and gynecological services required as a result of any gynecological examination or condition.

(11) Each managed health care plan, policy, or contract which is issued, delivered, issued for delivery, or renewed in this state on or after July 1, 1997, shall disclose to enrollees, subscribers, or insureds, in clear, accurate language, the female enrollee's right of direct access to a women's health care provider of her choice. The information shall be disclosed to each individual in a manner consistent with Subsection A of 13.10.13.14 NMAC. The information shall include, at a minimum, any specific women's health care services excluded from coverage, and shall include reference to the MHCP's right to limit coverage to medically necessary and appropriate women's health care services.

(12) No MHCP shall impose additional copayments, co-insurance, or deductibles for female enrollees' direct access to in-network, participating women's health care providers unless such additional cost-sharing is imposed for other types of health care services not delineated in this section.

(13) A MHCP may limit the number of visits to designated women's health care providers by female enrollees, provided that:

(a) at least one routine annual well-visit per female enrollee is allowed;

(b) follow-up treatment within sixty days following a well-visit is allowed for treatment of a condition diagnosed during a well-visit; and

(c) visits for any necessary care related to pregnancy are permitted.

(14) A MHCP may limit the number of women's health care providers included as primary care physicians, provided that a sufficient number of providers are available to serve a defined population or geographic service area so that female enrollees will have direct and timely access to women's health care providers.

(15) Nothing in this section requires any women's health care provider to enter into a contract with a MHCP whereby he or she must act as a primary care physician rather than as a referral specialist.

(16) A MHCP's criteria for accepting women's health care providers as primary care physicians must be the same as the criteria utilized by the MHCP for other specialists seeking to act as primary care physicians.

(17) A MHCP may limit female enrollees' access to those women's health care providers who have contracts and are participating providers.

H. **Health promotion program**: Each managed health care plan that provides coverage for comprehensive basic health care services in this state shall provide a preventative health services program and shall make the following services available to an enrollee only in those instances where the enrollee's primary care physician, in consultation with the MHCP, determines that such services are medically necessary:

(1) Periodic tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or, alternatively, a fractionated cholesterol level including a low-density lipoprotein (LDL) level and a high-density lipoprotein (HDL) level in accordance with recommendations of the U.S. preventive services task force.

(2) Periodic glaucoma eye tests for all persons 35 years of age or older in accordance with recommendations of the U.S. preventive services task force.

(3) Periodic stool examinations for the presence of blood for all persons 40 years of age or older in accordance with recommendations of the U.S. preventive services task force.

(4) Periodic left-sided colon examinations of 35 to 60 centimeters for all persons 45 years of age or older in accordance with recommendations of the U.S. preventive services task force.

(5) Immunizations for all adults as recommended by the U.S. preventive services task force.

(6) For all persons 20 years of age or older and as deemed medically necessary or recommended by a primary care physician, an annual consultation with a health professional to discuss lifestyle behaviors that promote health and well-being including, but not limited to, smoking control, nutrition and diet recommendations, exercise plans, lower back protection, immunization practices, breast self-examination, testicular self-examination, use of seat-belts in motor vehicles, and other preventative health care practices.

(7) Other preventative health services shall include, under an enrollee's primary care physician's supervision:

(a) reasonable health appraisal examinations and laboratory and radiological tests on a periodic basis when medically necessary;

(b) voluntary family planning services; and

(c) diagnosis and medically indicated treatments for physical conditions causing infertility except as required to reverse prior voluntary sterilization surgery.

I. **Diagnostic services**: Diagnostic services shall include diagnostic laboratory services, diagnostic and therapeutic radiological services, and other services in support of comprehensive basic health care services.

J. **Inclusion of basic health care services**: A MHCP may not provide or arrange to provide basic health care services if such services:

(1) do not include all the basic health services set forth in this section; or

(2) are limited as to time or cost except as prescribed in this section, subject to lifetime policy maximums.

K. **Other basic health care services**: A MHCP shall also provide the following additional health care services to its enrollees:

(1) General dental services when determined to be medically necessary by a participating provider in connection with the following: accidental injury to sound natural teeth, the jaw bones, or surrounding tissues; the correction of a non-dental physiological condition which has resulted in a severe functional impairment; or the treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

(2) Cosmetic surgery from which an improvement in physiologic function could reasonably be expected, when ordered by an enrollee's primary care physician or treating physician and performed for the correction of functional disorders resulting from accidental injury or from congenital defects or disease.

[3/16/97, 6/30/98, 12/1/98; 13.10.13.9 NMAC - Rn & A, 13 NMAC 10.13.9, 4/30/2007]

13.10.13.11 ACCESS TO HEALTH CARE SERVICES:

A. **Provider network adequacy**: Each health care insurer through its MHCP shall maintain and have available an adequate network of licensed primary care physicians to provide comprehensive basic health care services to its enrolled population at all times. On or before September 1, 1997, those MHCPs currently doing business in New Mexico shall submit to the superintendent for approval an access plan addressing all of the criteria of this section.

A MHCP new to this state shall submit a preliminary access plan to the [~~department~~] division as part of its application for licensure. A MHCP new to this state shall file a follow-up access plan with the superintendent within six months after it obtains a certificate of authority. The superintendent shall approve or reject an access plan submitted by a MHCP within 45 days after the access plan is submitted to the [~~department~~] division. In considering whether to approve or reject an access plan, the superintendent shall determine whether the MHCP meets all of the following criteria; however, the superintendent may make reasonable exceptions to the criteria on a case by case basis when the MHCP demonstrates the need for such exceptions.

(1) Whether, in population areas of 50,000 or more residents, two primary care physicians are available within no more than 20 miles or 20 minutes average driving time for 90 percent of the enrolled population, or, in population areas of less than 50,000, whether two primary care providers are available in any county or service area within no more than 60 miles or 60 minutes average driving time for 90 percent of the enrolled population. For remote rural areas, the superintendent shall consider on a case by case basis whether the MHCP has made sufficient PCPs available given the number of residents in the county or service area and given the community's standard of care.

(2) Whether the MHCP has a sufficient number of primary care physicians to meet the primary care needs of the enrolled population, using, as guidelines for calculation, the following criteria: 1) that each enrollee will have four primary care visits annually, averaging a total of one hour; 2) that each primary care physician will see an average of four patients per hour; and 3) that one full-time equivalent PCP will be available for every 1,500 enrollees.

(3) Whether the MHCP demonstrates that the projected PCP network is sufficient to meet the primary care needs of adult, pediatric, and obstetric-gynecological patients. Each MHCP should show the adequacy of primary care physician availability by verifying that the primary care physician has committed to provide sufficient time for new patients so that projected clinic hour needs of the projected enrollment by service area are met.

(4) Whether the MHCP provides reasonable and reliable access for its enrollees to qualified providers in those specialties that are covered by the MHCP. In developing its access plan, the MHCP should: 1) demonstrate that a sufficient number of licensed medical specialists are available to enrollees for specialty care when referral to such care is determined to be medically necessary by the PCP or other treating physician in consultation with the MHCP; and 2) attempt to provide at least one licensed medical specialist in those specialties that are generally available in the geographic area served, taking into consideration the urban or rural nature of the service area, the geographic location of each enrollee, and the type of specialty care needed by the enrollee population. Nothing in the proposed access plan should restrict a MHCP's ability to refer an enrollee to what is commonly known as a "center of excellence" or other referral center, even though such center may be geographically distant from the enrollee's residence, when it is determined by the PCP, in consultation with the MHCP, that treatment at such a center is medically necessary.

(5) Whether the MHCP has contracts, or other arrangements acceptable to the superintendent, with institutional providers so that: 1) the need for services covered by the MHCP is satisfied; 2) the medical needs of enrollees are met 24 hours per day, seven days per week; and 3) the institutional services are geographically accessible to enrollees. In its access plan, the MHCP should demonstrate that in population areas of 50,000 or more residents, at least one licensed acute care hospital providing, at a minimum, licensed medical-surgical, emergency medical, pediatric, obstetrical, and critical care services is available no greater than 30 miles or 30 minutes average driving time for 90 percent of the enrolled population within the service area, and, in population areas of less than 50,000, that the acute care hospital is available no greater than 60 miles or 60 minutes average driving time for 90 percent of the enrolled population within the service area. For remote rural areas, the superintendent shall consider on a case by case basis whether the MHCP has made at least one licensed acute care hospital available given the number of residents in the county or service area and given the community's standard of care.

(6) Whether a sufficient number of health professionals, such as registered and licensed practical nurses, are available to enrollees to ensure the delivery of covered health care services.

(7) Whether the MHCP has made surgical facilities including acute care hospitals for major surgery, hospitals for minor surgical procedures, licensed ambulatory surgical facilities, and medicare eligible surgical practices reasonably available, given the population of the service area and the institutional facilities available in or around the service area.

(8) Whether the MHCP has a policy assuring access to tertiary and specialized services as evidenced by contract or other agreement acceptable to the superintendent. In its access plan, the MHCP should describe the geographic location of and enrollees' accessibility to the following such services:

(a) at least one hospital providing regional perinatal services;

(b) a hospital offering tertiary pediatric services;

(c) a hospital offering diagnostic cardiac catheterization services;

(d) inpatient psychiatric services for adults and children, if provided as a supplemental health care service; and

(e) a residential substance abuse treatment center, if provided as a supplemental health care service.

(9) Whether the MHCP has a policy assuring access to the specialized services listed below, as evidenced by contract or other agreement acceptable to the superintendent. The MHCP should demonstrate in its access plan the geographic location of and enrollees' accessibility to the following such services:

(a) a therapeutic radiation provider;

(b) magnetic resonance imaging center;

(c) diagnostic radiology provider, including x-ray, ultrasound, and CAT scan; and

(d) a licensed renal dialysis center.

(10) Whether the MHCP has at least one licensed home health provider available to serve each service area where 3,000 or more enrollees reside, if home health care is provided as a supplemental health care service.

B. **Appointment waiting times**: Each MHCP shall demonstrate that the network will meet the following criteria:

(1) emergencies shall be triaged through the PCP or by a hospital emergency room through medical screening or evaluation;

(2) urgent care shall be available within 48 hours of notification to the PCP or MHCP, or sooner as required by the medical exigencies of the case;

(3) for both emergent and urgent care, the MHCP shall ensure that PCPs provide 7 day, 24 hour access to triage services, and that each PCP will have back-up coverage by another provider;

(4) the MHCP shall have an adequate number of PCPs with admitting privileges at one or more participating hospitals within the MHCP's service area so that necessary hospital admissions are made on a timely basis consistent with generally accepted practice parameters;

(5) routine appointments shall be scheduled as soon as is practicable given the medical needs of the enrollee and the nature of the provider's medical practice;

(6) routine physical exams shall be scheduled within 4 months;

(7) in all instances of scheduling, the MHCP or its participating providers shall have guidelines to assess when an appointment should be scheduled based on the type of health care service to be provided; upon request, the MHCP shall make such guidelines available to enrollees;

(8) all appointments shall be scheduled either during normal business hours or after hours (if applicable), depending upon the individual patient's needs and in accordance with the individual physician's scheduling practice.

C. **Referrals**: The MHCP shall implement a system that ensures routine referrals are made to other participating providers by either the MHCP or a participating provider. An enrollee shall not be held liable for payment of services if the MHCP provider mistakenly makes a referral to a non-participating provider, unless the MHCP has notified the enrollee in writing concerning the use of non-participating providers and informing the enrollee that the MHCP will not be responsible for future payment to the non-participating providers. The MHCP shall bear the burden of showing that the enrollee has been adequately informed by specific written notice of the MHCP's future refusal to pay for future care provided by the identified non-participating provider.

D. **Provider lists**: A MHCP must provide a list of all providers to subscribers or contract holders, and to individual or prospective enrollees upon request. The list shall include specialty providers and other health professionals providing health care services, and shall specify the location(s), including addresses, of such providers. The list shall identify those providers who are no longer able to accept new patients. The information shall be provided to enrollees in the evidence of coverage or enrollment materials.

E. **Out-of-network services**: Each contract, policy, or arrangement between a MHCP and an enrollee, subscriber, or contract holder must provide that in the event medically necessary covered services are not reasonably available through participating providers, the MHCP and the PCP or other participating provider shall refer an enrollee to a non-participating physician or provider and shall fully reimburse the non-participating physician or provider at the usual and customary rate or at an agreed upon rate. Each contract, policy, or arrangement must further provide that before a MHCP may deny such a referral to a non-participating physician or provider, the request must be reviewed by a specialist similar to the type of specialist to whom a referral is requested. In determining whether the rate to be paid to a non-participating physician or provider by the MHCP is "usual and customary," the [~~department~~] division may rely upon accepted insurance industry standards for determining such rates.

F. **Specialty care**: Referrals to participating or non-participating specialty physicians or providers must be accessible to enrollees on a timely and appropriate basis in accordance with generally accepted medical guidelines.

(1) If the MHCP requires enrollees to obtain prior authorization before referral to specialty care, the MHCP must provide enrollees the following information in the evidence of coverage or enrollment materials:

(a) procedures an enrollee must follow to obtain prior authorization for specialty referrals, including whether an enrollee's PCP, the MHCP's medical director, or a committee must first authorize the specialty referral;

(b) the necessity, if any, of repeating prior authorization if the specialist care is to be ongoing; and

(c) procedures to obtain a second medical opinion.

(2) The MHCP must inform PCPs of their responsibility to provide written referrals and of any specific procedures that must be followed in providing such referrals.

(3) The PCP must refer patients to those participating providers who are qualified to address the enrollee's health care needs as determined by the PCP in consultation with the MHCP.

(4) The MHCP shall make determinations on requests for referrals in accordance with Subsection D of 13.10.13.19 NMAC.

(5) Enrollees denied referral to specialty care by their PCP may initiate a grievance through the MHCP's grievance procedures pursuant to [~~13 NMAC 10.13.15~~] 13.10.17 NMAC.

(6) If, in the best medical judgment of the enrollee's primary care physician, the enrollee's health condition requires ongoing specialty care, such as for chronic illnesses requiring medical supervision beyond the capability or training of the PCP, the PCP may, after consultation with the specialist and the MHCP, refer the enrollee to the appropriate specialist for ongoing care as the severity of the condition warrants; however, the ultimate determination of whether the enrollee should have ongoing care from the specialist shall remain with the PCP. In such cases, neither the PCP nor the enrollee will be required to obtain a prior authorization from the MHCP for subsequent specialist visits. The MHCP may review such referrals to specialist care on an annual basis to determine whether ongoing specialist care continues to be medically necessary. In conducting such a review, the MHCP shall consult with the enrollee's primary care physician and the specialist to whom the enrollee has been referred.

(7) Nothing in Paragraph (6) of Subsection F of 13.10.13.11 NMAC prohibits a health care insurer or MHCP from requiring that enrollees receive ongoing specialist care from those specialists who are considered "participating providers" by the MHCP, unless there are no participating specialists of the type required to manage the patient's condition. In such instances, the MHCP shall make indemnity or other payment arrangements for the patient's care, and enrollees will not be assessed higher or additional co-payments as a result of such arrangements.

(8) A MHCP must allow qualified health care providers who are specialists to act as primary care providers for patients with chronic medical conditions of sufficient severity to require primary coordination of care by a specialist as determined by the enrollee, the enrollee's current treating physician, the enrollee's primary care physician if different than the treating physician, and the MHCP, provided that:

(a) the specialist offers all basic health care services that are required of them by the MHCP; and

(b) the specialist meets the MHCP's eligibility criteria for health care professionals who provide primary care.

G. **Out of state providers**: A MHCP may enter into contracts or other arrangements with out of state providers in order to meet the access requirements of this rule.

H. **Access to non-allopathic health care services**: In order to maximize enrollees' access to all types of health care services, the [~~department~~] division affirmatively encourages each health care insurer or MHCP to enter into appropriate contracts with qualified health care professionals, including but not limited to, doctors of oriental medicine, chiropractic physicians, nurse practitioners, physician assistants, or certified nurse midwives to provide both allopathic and non-allopathic health care services.

I. The MHCP shall ensure that an enrollee is not precluded from obtaining a referral from the enrollee's primary care physician to a specialist or other health care provider that is within the MHCP's network, if the referral is reasonable.

[3/16/97, 6/30/98; 12/1/98; 13.10.13.11 NMAC - Rn & A, 13 NMAC 10.13.11, 4/30/2007]

13.10.13.13 LICENSURE, CREDENTIALING, AND VERIFICATION OF HEALTH CARE PROFESSIONALS AND FACILITIES:

A. All health care insurers offering, selling, issuing, or providing managed health care plans in New Mexico shall assure that all participating providers, including health care professionals and health facilities, are licensed to practice or operate in this state if a license is required by applicable New Mexico laws.

B. MHCPs who contract with health professionals or facilities outside New Mexico for the provision of health care services to New Mexico residents must assure that such health professionals or facilities are licensed to practice or operate in the state where the professional or facility is located, pursuant to that state's applicable laws, if a license is required by that state.

C. MHCPs shall establish and maintain a comprehensive credentialing verification program for health professionals and facilities to ensure that its participating health professionals and facilities meet specific minimum standards of professional qualification. A MHCP shall:

(1) Establish written policies and procedures for credentialing verification of all health professionals and facilities with whom the MHCP contracts to supply health care services to its enrollees, and shall apply these standards consistently.

(2) Verify the credentials of a health professional or facility before such professional or facility provides care to an enrollee under a contract with the MHCP. The medical director of the MHCP or other designated, responsible person shall have responsibility for, and shall participate in, health professional or facility credentialing verification.

(3) Establish a credentialing verification committee consisting of licensed physicians and other health professionals to review credentialing verification information and supporting documents and make decisions regarding credentialing verification.

(4) Make available for review by the applying health professional or facility, upon written request, all application and credentialing verification policies and procedures.

(5) Keep confidential all information obtained in the credentialing verification process, except as otherwise provided by law.

D. Physicians qualified to function as primary care physicians include but are not limited to: licensed physicians who have successfully completed a residency program accredited by the accreditation council for graduate medical education or approved by the American osteopathic association in family practice, internal medicine, general practice, pediatrics, obstetrics and gynecology or who are diplomats of one of the above certifying boards approved by the American board of medical specialties or one of the certifying boards of the American osteopathic association.

E. Nothing in this section requires MHCPs to contract with a provider solely because he or she meets the MHCP's credentialing verification standards, or prevents MHCPs from utilizing separate or additional criteria in selecting health professionals with whom they contract.

F. MHCPs shall obtain primary verification of the following information about its provider applicants, if applicable:

(1) current license, certificate of authority, or registration to practice or operate in this state, and history of licensure;

(2) graduation from applicable health professional school or program;

(3) completion of post graduate training;

(4) current level of professional liability coverage;

(5) status of hospital staff privileges to ensure that a sufficient number of participating providers have admitting privileges with at least one hospital used by the MHCP;

(6) specialty board certification status;

(7) current drug enforcement agency registration certificate.

G. At least every [~~two~~] three years, MHCPs shall repeat primary verification of its participating providers and facilities to assure ongoing compliance with this section.

H. In addition to the requirements set forth in Subsection F of 13.10.13.13 NMAC, MHCPs may obtain, subject to primary or secondary verification at the MHCP's discretion, additional information, including, but not limited to, the following:

(1) the health professional's or facility's license history in this and all other states;

(2) the health professional's or facility's malpractice history as reported by the national practitioners data bank;

(3) the health professional's or facility's practice history including revocation or suspension of a state license or DEA number, any curtailment or suspension of medical staff privileges, other than for incomplete medical records, any sanctions imposed by medicare and/or medicaid, and any censure by the New Mexico board of medical examiners.

I. MHCPs shall provide health care professionals or facilities the opportunity to review and correct information submitted in support of that health care professional's or facility's credentialing verification application.

J. A MHCP may contract with another entity to perform the credentialing functions required of this section. Whenever a MHCP enters into such a contract, the superintendent shall hold the MHCP responsible for monitoring the activities of the entity with which it contracts and for ensuring that the requirements of this section are met.

K. **Accreditation by nationally recognized accrediting entity**: Nothing in this section shall prohibit a MHCP from submitting accreditation by a nationally recognized accrediting entity as evidence of compliance with the requirements of this section. In those instances where a MHCP seeks to meet the requirements of this section through accreditation by a private accrediting entity, the MHCP shall submit to the [~~department~~] division the following information: 1) current standards of the private accrediting entity in order to demonstrate that the entity's standards meet or exceed the requirements of this rule; 2) documentation from the private accrediting entity showing that the MHCP has been accredited by the entity; and 3) a summary of the data and information that was presented to the private accrediting entity by the MHCP and upon which accreditation of the MHCP was based. A MHCP accredited by the private accrediting entity that has submitted all of the requisite information to the [~~department~~] division may then be deemed by the superintendent to have met the requirements of the relevant provisions of this section where comparable standards exist, provided that the private accrediting entity from which the MHCP obtained accreditation is recognized and approved by the superintendent.

[3/16/97, 6/30/98; 13.10.13.13 NMAC- Rn & A, 13 NMAC 10.13.13, 4/30/2007]

13.10.13.14 INFORMATION PROVIDED TO ENROLLEES AND READABILITY OF MANAGED HEALTH CARE PLAN CONTRACTS:

A. Each evidence of coverage or disclosure form offered to subscribers, enrollees, and prospective enrollees upon request by a health care insurer through its MHCP shall state in clear, accurate, and conspicuous language, in not less than 10 point font, written such that it can be easily understood by the average enrollee, and so that it comports with the requirements of the "Policy Language Simplification Law," Chapter 59A, Article 19 NMSA 1978, the following information.

(1) The name of the health care insurer and/or managed health care plan and its principal place of business, including its address and telephone number.

(2) Definitions for words that have meanings other than common general

usage.

(3) A description of the MHCP's service area.

(4) A complete list or description of the comprehensive basic health care services, urgent health care services, emergency health care services, and, if applicable, supplemental health care services available within the MHCP's service or geographical area, and any other benefits to which the enrollee is entitled under the particular plan.

(5) An explanation of how participation in the managed health care plan may affect the potential enrollee's choice of physician, hospital, or other health care provider.

(6) A description of the following:

(a) eligibility requirements for coverage, including a statement of conditions on eligibility for benefits;

(b) conditions of cancellation, which shall include a statement that if an enrollee believes coverage was canceled due to health status or health care requirements, he or she may appeal termination to the superintendent;

(c) the name, address, and toll-free telephone number of the superintendent;

(d) a statement that a copy of the insurance contract will be provided upon request if the enrollee is unable to obtain a copy of the contract from the enrollee's employer or other contract holder;

(e) conditions for renewal and reinstatement; and

(f) any procedures for filing claims.

(7) In bold typeface, any and all exclusions or limitations on the health care services, type of health care services, benefits, or type of benefits to be provided, including deductibles or copayments, or co-insurance.

(8) Any other requirements or procedures necessary for enrollees to obtain particular health care services, such as additional copayments, prior authorizations, second opinions, and consultations with or referrals to specialists, physicians, or other providers other than the primary care physician.

(9) The enrollee's personal financial obligation for non-covered health care services.

(10) A clear and complete summary of where, and in what manner, information is available regarding how an enrollee obtains services, including emergency and out-of-area services. The evidence of coverage and any enrollee membership card issued by the MHCP shall contain a toll-free telephone number through which the enrollee may contact the MHCP for additional information on obtaining health care services or for other inquiries regarding the plan, including benefit information and plan requirements. The toll-free telephone number shall:

(a) be answered twenty-four hours a day, seven days a week so that enrollees who need assistance may obtain answers to their questions; and

(b) be equipped so that enrollees with non-medical benefit information questions may leave a voice-mail message for the MHCP that the administrative office of the MHCP will answer before 5:00 p.m. of the next business day.

(11) For all contracts, a list of relevant copayments and all other out of pocket expenses paid by the enrollee. For individual and conversion contracts, the contractual periodic prepayment or premium, must be listed and may be contained in a separate insert. In addition, for individual and conversion contracts, both the total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay must be listed.

(12) A description of the MHCP's grievance procedures and method for resolving enrollee complaints, including a description of the appeals process available if the MHCP limits or excludes coverage of a treatment or procedure, the address and telephone number to which grievances are to be directed, and a statement identifying the superintendent as an external source with whom grievances may be filed, including the [~~department~~] division of insurance address and toll-free telephone number so that the enrollee may submit the complaint.

(13) If the MHCP provides prescription drug coverage, the evidence of coverage or disclosure form must convey in clear and concise language: 1) whether participating providers are restricted to prescribing drugs from a drug formulary; 2) whether or not brand-name products require a higher copayment; 3) the extent, if at all, to which an enrollee will be reimbursed for costs of a drug that is not on the plan's formulary; 4) how enrollees may obtain, upon request, a complete list of drugs covered by the plan or listed on the MHCP's drug formulary; and 5) any exclusions or limitations for coverage of "experimental" or "investigational" drugs. The MHCP shall include definitions of "experimental" and "investigational" as those terms are used by the MHCP.

(14) A list of providers, which contains all of the information listed in Subsection D of 13.10.13.11 NMAC.

(15) A statement regarding whether or not participating providers must comply with any specified numbers, targeted averages, or maximum durations of patient visits; if the MHCP has such an arrangement, the evidence of coverage or disclosure must state the specific requirements.

(16) A statement reflecting that an enrollee will not be liable to a provider for any sums owed to the provider by the MHCP; the MHCP may include language reflecting that the enrollee may be liable for sums owed to a non-contracting provider, except when an enrollee is mistakenly referred to a non-participating provider by a MHCP provider as discussed in Subsection C of 13.10.13.11 NMAC.

B. The MHCP shall provide subscribers with written bi-annual notices of any deletions or additions to the list of primary care physicians in their area, and shall make more recent updated lists available to enrollees upon request. The bi-annual notices may be included in other written materials that are sent to subscribers.

C. The MHCP shall use a current list of providers, including health professionals and facilities, when soliciting individuals or groups for enrollment in the MHCP.

D. Upon request of an enrollee, prospective enrollee, or subscriber, the MHCP shall provide information on participating providers, including their education, training, applicable certification, and any sub-specialty.

E. When a health care insurer through its MHCP terminates or suspends any contract with a participating provider, it must notify, in writing, affected enrollees who are current patients of or assigned to the provider within 30 days. The notice to enrollees shall advise them of their right to continue receiving care from the provider as set forth in 13.10.13.28 NMAC. The health care insurer shall assist such affected enrollees in locating and transferring to another similarly qualified provider. An enrollee may not be held financially liable for services received from the provider in good faith between the effective date of the suspension or termination and the receipt of notice provided to the enrollee, if the enrollee has not received comparable notice during this time from the provider.

F. Before issuing any change in premium in an individual contract, a MHCP must provide a 30-day written notice to the affected subscriber(s) in the manner the MHCP customarily provides such notice. Before issuing any change in coverage in an individual contract, a MHCP must provide a 30-day written notice to the affected subscriber(s) in the manner the MHCP customarily provides such notice. The notice shall state the reason(s) for the premium rate changes, plan design, or plan benefit changes.

G. On or before June 1, 1997, each MHCP currently doing business in this state must disclose to the superintendent and to its contracting providers the

process by which the MHCP authorizes or denies health care services rendered by its providers pursuant to the benefits covered by the plan. Any MHCP claiming that such information is proprietary has the burden of showing to the superintendent that the information requested is in fact proprietary. Health care insurers planning to offer a new MHCP in this state must disclose such information to the superintendent prior to when the health care insurer solicits individuals or groups for enrollment in the MHCP. In addition, each MHCP shall make available such information to enrollees, prospective enrollees, or subscribers upon request.

H. Upon request of enrollees, prospective enrollees, or subscribers, the MHCP shall provide copies of its quality assurance plans and patterns of its utilization of services that the MHCP routinely tracks. A MHCP may provide such information through such nationally recognized reporting data bases, such as, for example, the health plan employer data and information set (HEDIS).

[3/16/97, 6/30/98; 12/1/98; 13.10.13.14 NMAC - Rn & A, 13 NMAC 10.13.14 NMAC, 4/30/2007]

13.10.13.15 [~~GRIEVANCE SYSTEM:~~

~~A. In general: Every MHCP shall establish and maintain written procedures to provide for the presentation, management, and resolution of complaints and grievances brought by enrollees or by providers acting on behalf of an enrollee and with the enrollee's consent, regarding any aspect of the MHCP's health care services, including but not limited to complaints regarding quality of care, choice of providers, network adequacy, cancellation, or nonrenewal of coverage, and utilization management determinations. An officer or other responsible authority of the MHCP shall be designated as having primary responsibility for the maintenance of such a procedure, for review of its operation, and for the utilization of any emergent patterns of grievances in the formulation of policy changes and procedural improvements in the MHCP's administration. All general grievance systems shall meet the criteria contained in this section. Utilization management grievances shall be governed by the specific requirements of 13 NMAC 10.13.15.15 [now Subsection O of 13.10.13.15 NMAC]. When processing grievances, the MHCP shall determine whether a particular grievance involves a utilization management determination resulting in a denial, termination or other limitation of covered health care services. In those instances where the MHCP is uncertain whether a particular grievance involves a utilization management determination as described in this section, the MHCP should process the grievance as one involving a utilization management determination.~~

~~B. Written notification: The MHCP shall provide written notification to all enrollees and providers that a grievance procedure is available. The written information must explain how the MHCP processes and resolves grievances, and must provide a toll-free or no-cost telephone number and business address of the MHCP department responsible for resolving grievances. A detailed written explanation of the grievance procedure shall be provided to an enrollee when adverse action is taken by the MHCP against an enrollee.~~

~~C. Information for enrollees: A concise description of the MHCP's grievance procedures shall be included, in bold typeface, in the evidence of coverage and in enrollment materials or benefit booklets issued to enrollees.~~

~~D. Complaint forms: Complaint forms and a copy of grievance procedures shall be made readily available by the MHCP and shall be promptly provided to an enrollee upon oral or written request.~~

~~E. Enrollee assistance: The MHCP shall notify enrollees that an enrollee services representative, such as a patient representative or ombudsperson, provided by the MHCP, is available upon request to assist enrollees with grievance procedures.~~

~~F. Oral complaints: In those instances where an enrollee initially makes an oral complaint to the MHCP and expresses interest in pursuing a written grievance, the MHCP shall assist the enrollee in making a written complaint or initiating a grievance.~~

~~G. Record of complaints: The MHCP shall have a system to record and document the status of all written complaints which shall serve as the basis for subsequent contact and investigation. Such records shall be maintained by the MHCP for at least three years. Each complaint received in person or by telephone shall document the date, identification of the complainant, the individual to whom the complaint was made, and how the complaint was resolved.~~

~~H. Complaint procedure: Within 7 days after the MHCP receives a complaint, it shall send the complainant a written acknowledgment that the MHCP has received the complaint. The acknowledgment notice shall contain the name of a MHCP employee to contact regarding the complaint.~~

~~I. Follow-up on complaints: The MHCP shall develop procedures for follow-up action on complaints, including methods to timely notify the complainant in writing of the disposition of the complaint. The written notice shall inform the complainant that he or she may contact the MHCP for further information regarding the reasoning for the MHCP's decision, including information regarding corrective action that may have been taken by the MHCP. In those instances where the MHCP decides against a complainant, the MHCP shall include the reasoning for the adverse decision in the written notice sent to the complainant. The written notice shall also inform the complainant that he or she may file a complaint with the superintendent if he or she is dissatisfied with the response from the MHCP, and shall contain the toll-free telephone number and address of the superintendent. "Timely notice" may vary depending on the particular facts and circumstances of each complaint; however, in any event the MHCP shall notify a complainant regarding the disposition of his or complaint within 5 days after the MHCP has arrived at a disposition.~~

~~J. Review of complaints: The MHCP shall promptly review complaints. The review shall be conducted by MHCP management or supervisory staff or by the MHCP department responsible for the particular services which are the subject of the complaint. The MHCP shall assume that every complaint constitutes a grievance until the MHCP affirmatively confirms that: 1) the subject matter of the complaint may be resolved without processing the complaint through the MHCP's internal grievance process; or 2) the grievant does not wish to pursue a grievance. For matters other than utilization review determinations, the MHCP's internal grievance review shall consist of an initial investigation and review and a second level review.~~

~~(1) The initial investigation shall:~~

~~(a) be conducted by a committee consisting of one or more employees of the MHCP; at least one such employee must be authorized to take corrective action on the grievance;~~

~~(b) allow the enrollee to present data pertinent to the grievance, including but not limited to written materials, medical records, medical literature, and statements or letters from providers;~~

~~(c) be completed no later than 10 days after the enrollee has submitted all information he or she wishes the committee to review; and~~

~~(d) be binding unless the grievant submits a written appeal to the second level review committee within 30 days of receipt of the committee's written decision.~~

~~(2) A written decision from the level one committee shall be mailed to the enrollee no later than 30 days after the~~

enrollee has submitted all information and materials he or she wishes the committee to consider. The written decision shall contain the following:

(a) The names, titles, and qualifying credentials of the person or persons participating in the initial investigation and review process (the reviewers).

(b) A statement of the reviewers' understanding of the grievance.

(c) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the grievant to respond further to the MHCP's position.

(d) A reference to the evidence or documentation used as the basis for the decision.

(e) In cases involving a medical determination adverse to the grievant, a summary of the clinical rationale for the determination, and instructions for requesting a detailed written statement of the clinical rationale, including the clinical review criteria used to make the determination.

(f) If applicable, a statement describing: 1) the process to obtain a second level grievance review of the decision; and 2) the written procedures governing a second level review, including any required time deadlines for review.

(g) Notice of the grievant's right to contact the superintendent of insurance if he or she is dissatisfied with the resolution reached through the MHCP's internal grievance process. The notice shall contain the toll-free telephone number and address of the superintendent's office.

(3) In those cases where the grievant does not appeal to the second level review committee, the initial investigation, review, and disposition of a grievance shall be completed within 30 days of the MHCP's receipt of the complaint, and no later than 5 days, if necessary, for urgent care situations, out-of-network services, medically necessary care, or as may be required by 13 NMAC 10.13.19 [now 13.10.13.19 NMAC]. The 30-day period may be extended when there is a delay in obtaining documents or records necessary for the resolution of the grievance, or by mutual written agreement of the MHCP and the grievant, provided that the MHCP notifies the grievant in writing of the need for an extension, the reason(s), and when resolution may be expected, and only in those instances where the MHCP can demonstrate that the delay will not result in increased medical risk to the enrollee.

(4) The grievant shall be entitled to review of the decision of the initial review committee by a second level review committee. The secondary review shall: 1) be conducted by a committee consisting of one or more employees of the MHCP, provided that no more than half of the committee members participated on the initial review committee; and 2) be binding unless the grievant submits a written appeal to the superintendent within 30 days after receipt of a decision from the second level review committee.

(5) An grievant may request to appear in person before the second level review committee. A MHCP's procedures for conducting a second level review shall include the following:

(a) The second level review committee shall schedule and hold a hearing within thirty (30) days after receiving a request from a grievant for a second level review, or sooner as required by the medical exigencies of the case. The hearing shall be held during regular business hours at a location reasonably accessible to the enrollee. In cases where a face to face hearing is not practical for geographic reasons, a MHCP shall offer the grievant the opportunity to communicate with the review committee, at the MHCP's expense, by conference call, video conferencing, or other appropriate technology. The grievant shall be notified in writing of the hearing date at least fifteen (15) days in advance. The MHCP shall not unreasonably deny a request for postponement of the review made by an grievant.

(b) Upon request of a grievant, a MHCP shall provide to the grievant all relevant information that is not confidential or privileged.

(c) A grievant has the right to: 1) attend the second level review hearing; 2) present his or her case to the review committee; 3) submit supporting material both before and at the review hearing; 4) ask questions of any representative of the MHCP; and 5) be assisted or represented by a person of his or her choice.

(d) The notice informing the grievant of the hearing date shall advise the grievant of the rights specified in 13 NMAC 10.13.15.10.5.3 [now Subparagraph (c) of Paragraph (5) of Subsection J of 13.10.13.15 NMAC].

(e) If the MHCP desires to have an attorney present to represent the interests of the MHCP, the notice informing the grievant of the hearing date shall advise the grievant that an attorney will be present and that the grievant may wish to obtain legal representation of his or her own. If the grievant obtains an attorney to represent him or her at the hearing, the grievant's attorney shall inform the MHCP in writing that the grievant has retained counsel who will appear at the hearing.

(6) A written decision from the second level review committee shall be mailed to the grievant within 10 days after any hearing at which the grievant appears or within 10 days after the grievant has submitted all information and materials he or she wishes the committee to consider. The written decision shall contain the following:

(a) The names, titles, and qualifying credentials of the persons on the review committee.

(b) A statement of the review committee's understanding of the nature of the grievance and all pertinent facts.

(c) The rationale for the review committee's decision.

(d) Reference to evidence or documentation considered by the review committee in making the decision.

(e) In cases involving a medical determination adverse to the grievant, a summary of the clinical rationale for the determination, and instructions for requesting a detailed written statement of the clinical rationale, including the clinical review criteria used to make the determination.

(f) Notice of the grievant's right to appeal the decision to the superintendent, including a description of all procedures and time deadlines necessary to perfect such an appeal and to whom the appeal should be directed. The notice shall contain the toll-free telephone number and address of the superintendents office.

K. Submission of grievance to superintendent: Enrollees may submit their grievances to the superintendent at any time during the grievance process; however, the superintendent may, in his or her discretion, require the enrollee to exhaust the MHCP's grievance procedures if the enrollee has not done so. The time requirements for grievances as outlined in this section shall not be tolled if an enrollee submits a grievance to the superintendent prior to exhausting the MHCP's grievance procedures.

L. Participation on review committee: A MHCP may choose to include at least one enrollee, member, or subscriber, other than the grievant, for participation on its second level review committee.

M. Retaliatory action prohibited: An enrollee who exercises the right to file a grievance under this section or any other section shall not be subject to retaliatory action by the health care insurer or MHCP such as disenrollment, cancellation of contract, or limited access to care due to filing a grievance or for any reason which is the subject of the written grievance, except where the coverage is being terminated for good faith grounds and in accordance with 13 NMAC 10.13.17 [now 13.10.13.17 NMAC].

N. Quality of care complaints: The MHCP shall submit information regarding all quality of care complaints to the MHCP's continuous quality improvement committee.

O. Utilization management grievances:

(1) All MHCP enrollees, and any provider acting on behalf of an enrollee

with the enrollee's consent, may file a grievance regarding any utilization management determination resulting in a denial, termination, or other limitation of covered health care services in accordance with the provisions set forth below. Procedures for utilization management grievances shall be governed by the specific requirements of this section.

(2) All enrollees and providers shall be provided with a written explanation of the grievance procedure for utilization management determinations in the evidence of coverage, in enrollment materials or benefit booklets issued to enrollees, when adverse action is taken by the MHCP against an enrollee, and upon the conclusion of each stage in the process as described below.

(3) The utilization review grievance process shall consist of an informal internal review by the MHCP (stage 1 review), a formal internal review by the MHCP (stage 2 review), and a formal external review (stage 3 review) by an independent utilization review board (IURB).

P. Informal internal utilization management review (stage 1):

(1) Each MHCP shall establish and maintain an informal internal grievance procedure (stage 1 review) whereby any enrollee or any provider acting on behalf of an enrollee with the enrollee's consent, who is dissatisfied with any MHCP utilization management determination, shall have the opportunity to appeal that determination to the MHCP medical director and/or the physician designee who rendered the determination.

(2) All such stage 1 reviews shall be concluded as soon as possible in accordance with the medical exigencies of the case, which in any event, shall not exceed 48 hours in the case of grievances from determinations regarding urgent or emergency care, and seven days in the case of all other grievances.

(3) If the grievance is not resolved to the satisfaction of the grievant at this level, the MHCP shall provide the grievant with a written decision. The written decision shall contain all information specified in 13 NMAC 10.13.15.10.2 [now Paragraph (2) of Subsection J of 13.10.13.15 NMAC]. If the grievance is resolved to the grievant's satisfaction, the MHCP shall provide the grievant with a written decision; however, the MHCP is not required to include in the decision all information specified in 13 NMAC 10.13.15.10.2 [now Paragraph (2) of Subsection J of 13.10.13.15 NMAC]. The stage 1 review shall be binding unless the grievant submits a written appeal to the formal internal utilization review panel within 30 days of receipt of the MHCP's written decision resulting from the stage 1 review.

Q. Formal internal utilization management review (stage 2):

(1) Each MHCP shall establish and maintain a formal internal review process (stage 2 review) whereby any enrollee or any provider acting on behalf of an enrollee with the enrollee's consent, who is dissatisfied with the results of the stage 1 review, shall have the opportunity to pursue his or her grievance before a panel of physicians and/or other health professionals selected by the MHCP who have not been previously involved in the utilization management determination at issue.

(2) The formal internal utilization management review panel shall have available consultant practitioners who are trained or who practice in the same specialty as would typically manage the case at issue, or such other health professional as may be mutually agreed upon by the parties. In no event, however, shall the consulting practitioner or professional have been involved in the utilization management determination at issue. The consulting practitioner or professional shall participate in the panel's review of the case if requested by the enrollee and/or provider. The grievant may also designate a specialist to participate in the panel's review of the case at his or her own expense.

(3) All stage 2 reviews must be acknowledged by the MHCP, in writing, to the enrollee or provider filing the grievance within seven days of receipt by the MHCP.

(4) All stage 2 reviews shall be concluded as soon as possible after receipt by the MHCP in accordance with the medical exigencies of the case which, in any event shall not exceed 48 hours in those cases requesting review from determinations regarding urgent or emergent care and, except as set forth in 13 NMAC 10.13.15.17.5 [now Paragraph (5) of Subsection Q of 13.10.13.15 NMAC], 30 days in the case of all other grievances.

(5) The MHCP may extend the review for up to an additional 20 days where it can demonstrate reasonable cause for the delay beyond its control, where it provides a written progress report and explanation for the delay to the enrollee and/or provider within the original 30 day review period, and where it can demonstrate that the delay will not result in increased medical risk to the enrollee. In no event, however, may the review period applicable to grievances from determinations regarding urgent or emergent care be so extended.

(6) A grievant may request to appear in person before the formal internal utilization management review panel (panel). A MHCP's procedures for conducting a formal internal utilization review shall include the following:

(a) The panel shall schedule and hold a hearing as soon as possible after receiving a request from a grievant to appear before the panel; however, in any event, in the case of requests for review from determinations regarding urgent or emergent care, the panel shall attempt to hold the hearing with 24 hours after receiving a request from an grievant, and within 10 days in the case of all other grievances. The grievant shall be notified either orally or in writing of the hearing date. The MHCP shall not unreasonably deny a request for postponement of the review made by the grievant.

(b) Upon request of a grievant, a MHCP shall provide to the grievant all relevant information that is not confidential or privileged.

(c) An grievant has the right to: 1) attend the formal internal utilization management review; 2) present his or her case to the panel; 3) submit supporting material both before and at the review hearing; 4) ask questions of any representative of the MHCP; and 5) be assisted or represented by a person of his or her choice.

(d) Any notice informing the grievant of the hearing date shall advise the grievant of the rights specified in 13 NMAC 10.13.15.17.6.3 [now Subparagraph (c) of Paragraph (6) of Subsection Q of 13.10.13.15 NMAC].

(e) If the MHCP desires to have an attorney present to represent the interests of the MHCP, any notice informing the grievant of the hearing date shall advise the grievant that an attorney will be present and that the grievant may wish to obtain legal representation of his or her own.

(7) A written decision from the panel shall be mailed to the enrollee as soon as possible given the medical exigencies of the case which, in any event shall not exceed 48 hours in those cases involving urgent or emergent case and, except as set forth in 13 NMAC 10.13.15.17.5 [now Paragraph (5) of Subsection Q of 13.10.13.15 NMAC], 30 days in the case of all other grievances. The written decision shall contain the following:

(a) the names, titles, and qualifying credentials of the persons on the review panel;

(b) a statement of the review panel's understanding of the nature of the grievance and all pertinent facts;

(c) the rationale for the review panel's decision;

(d) reference to evidence or documentation considered by the review panel in making the decision;

(e) in cases involving a medical determination adverse to the grievant, a summary of the clinical rationale for the determination, and instructions for request-

ing a detailed written statement of the clinical rationale, including the clinical review criteria used to make the determination;

(f) notice of the grievant's right to proceed to an external (stage 3) review, including a description of all procedures and time deadlines necessary to pursue such a review, and including any forms required to initiate such an external review.

(8) In the event that the MHCP fails to comply with any of the deadlines for completion of the internal utilization management determination reviews set forth in this section, or in the event that the MHCP for any reason expressly waives its rights to an internal review of any grievance, then the enrollee and/or provider shall be relieved of his or her obligation to complete the MHCP internal review process and may, at his or her option, proceed directly to the external review process set forth below.

R. External review process:

(1) Every MHCP enrollee, and any provider acting on behalf of an enrollee with the enrollee's consent, who is dissatisfied with the results of the internal grievance process set forth at 13 NMAC 10.13.15.15 through 10.13.15.17 [now Subsections O through Q of 13.10.13.15 NMAC], shall have the right to review of his or her grievance by an independent utilization review board (IURB) in accordance with the procedures set forth below (stage 3 review). Except as set forth in 13 NMAC 10.13.15.17.8 [now Paragraph (8) of Subsection Q of 13.10.13.15 NMAC], the right to an external review under this section shall be contingent upon the grievant's full compliance with both stages of the MHCP's internal appeal process set forth in 13 NMAC 10.13.15.16 and 10.13.15.17 [now Subsections P and Q of 13.10.13.15 NMAC].

(2) To initiate an external review, an enrollee and/or provider must, within 30 days from receipt of the written determination of the stage 2 internal review panel under 13 NMAC 10.13.15.17.7 [now Paragraph (7) of Subsection Q of 13.10.13.15 NMAC], file a written request with the department of insurance. The request shall be filed on the forms provided to the grievant in accordance with 13 NMAC 10.13.15.17.7.6 [now Subparagraph (f) of Paragraph (7) of Subsection Q of 13.10.13.15 NMAC], and shall include a general release executed by the enrollee for all medical records pertinent to the grievance. The request shall be mailed to the following address: superintendent of insurance, state corporation commission [public regulation commission] P.O. Box 1269 Santa Fe, New Mexico 87504-1269.

(3) Upon receipt of the written request together with the executed release, department staff shall immediately review the request. The review shall be concluded as soon as possible in accordance with the medical exigencies of the case, which, in any event, shall not exceed 48 hours in the case of grievances from determinations regarding urgent or emergency care, and twenty-one days in all other cases. The superintendent shall only accept a request for processing upon recommendation of department staff that the request reasonably appears to be meritorious. In deciding if a request reasonably appears to be meritorious, department staff shall consider whether:

(a) The individual was or is an insured of the MHCP.

(b) The service which is the subject of the complaint or appeal reasonably appears to be a covered service under the benefits provided by contract to the enrollee.

(c) Except as set forth in 13 NMAC 10.13.15.17.8 and 10.13.15.11 [now Paragraph (8) of Subsection Q and Subsection K of 13.10.13.15 NMAC], the enrollee has fully complied with both the stage 1 and stage 2 reviews available pursuant to this section.

(d) The enrollee has provided all information required by the IURB and the department to make the preliminary determination, including the written request form and a copy of any information provided by the MHCP regarding its decision to deny, reduce or terminate the covered service, and a fully executed release to obtain any necessary medical records from the MHCP and any other relevant health professional or provider.

(4) Upon completion of the initial review, the superintendent shall immediately notify the enrollee and/or provider in writing regarding whether the grievance has been accepted for processing and if not so accepted, the reasons for rejection of the grievance. If the grievance is accepted for processing, the superintendent shall immediately assign the case to an IURB for review in accordance with 13 NMAC 10.13.15.19.3 [now Paragraph (3) of Subsection S of 13.10.13.15 NMAC].

(5) Upon assignment of the grievance from the superintendent, the IURB shall conduct a full review to determine whether, as a result of the MHCP's utilization management determination, the enrollee was deprived of medically necessary covered services. In reaching this determination, the IURB shall take into consideration all pertinent medical records, consulting physician reports and other documents submitted by the parties, any applicable, generally accepted practice guidelines developed by the federal government, national or professional medical societies, boards and associations, and any applicable clinical protocols and/or practice guidelines developed by the MHCP pursuant to this rule.

(6) Both the grievant and one representative of the MHCP may request to appear in person before the IURB. The IURB's procedures for conducting a stage 3 review shall include the following:

(a) The IURB shall schedule and hold a hearing as soon as possible after receiving a request from an enrollee or from a representative of the MHCP to appear before the board. The enrollee and representative of the MHCP shall be notified either orally or in writing of the hearing date. The IURB shall not unreasonably deny a request for postponement of the hearing made by the enrollee or representative of the MHCP.

(b) An enrollee and one representative of the MHCP have the right to: 1) attend the IURB hearing; 2) present his or her case to the IURB; 3) submit supporting material both before and at the hearing; 3) submit supporting material both before and at the hearing; 4) ask questions of any representative of the IURB; and 5) be assisted or represented by an attorney or other person of his or her choice. Testimony at the hearing shall be taken under oath. The hearing shall be stenographically recorded at the department's expense. At the close of the hearing, the IURB shall deliberate in a closed session regarding the grievance at issue, with only IURB members and department staff assigned to assist the IURB present.

(c) The superintendent may attend the IURB hearing to observe but shall not participate in the proceedings.

(d) Any notice informing the enrollee and representative of the MHCP of the hearing date shall advise the enrollee and representative of the MHCP of the rights specified in 13 NMAC 10.13.15.18.6.2 [now Subparagraph (b) of Paragraph (6) of Subsection R of 13.10.13.15 NMAC].

(7) When necessary, the IURB shall consult with a physician in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the grievance. All final recommendations of the IURB shall be approved by a majority of the IURB.

(8) The IURB shall complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case which, in any event, except as provided for herein, shall not exceed 30 days from receipt of all documentation necessary to complete the review. The IURB may, however, extend its review for a reasonable period of time as may be necessary due to circumstances beyond its control, but only when the delay will not result in increased medical risk to the enrollee. In such an event the IURB shall, prior to the conclusion of the initial

~~review period, provide written notice to the enrollee and/or provider and to the MHCP setting forth the status of its review and the specific reasons for the delay.~~

~~(9) If the IURB determines that the enrollee was deprived of medically necessary covered services, the IURB shall recommend to the enrollee, the MHCP and the superintendent, the appropriate covered health care services the enrollee should receive. Within seven days after the superintendent receives the IURB's recommended decision, the superintendent shall inform the enrollee, the MHCP, and the IURB in writing of whether the superintendent believes: 1) there is a reasonable basis upon which an order could be issued requiring the MHCP to show cause why the IURB's recommended decision should not be implemented; or 2) there is not a reasonable basis upon which to implement the IURB's recommended decision.~~

~~(10) In those instances where the superintendent informs the MHCP that there is a reasonable basis upon which an order could be issued requiring the MHCP to show cause why the IURB's recommended decision should not be implemented, within ten days of receiving such notification, the MHCP shall submit a written report to the IURB, the enrollee, and the department staff indicating whether it will accept and implement or reject the recommendations of the IURB. In the case of a rejection, the MHCP shall specifically state in its report each and every basis for its rejection of the IURB's recommendation. If the MHCP refuses to comply with the IURB's recommendation, department staff may institute proceedings against the MHCP under all applicable provisions of the Insurance Code.~~

~~(11) Within ten days of receipt of the superintendent's notification outlined in 13 NMAC 10.13.15.18.9.1 [now Subparagraph (a) of Paragraph (9) of Subsection R of 13.10.13.15 NMAC], the MHCP may also submit a written request for a formal hearing before the superintendent. Upon receipt of a request for hearing, the superintendent shall schedule a formal hearing pursuant to the Insurance Code. In those instances where the MHCP requests a formal hearing, staff counsel for the department shall defend the IURB's decision.~~

~~(12) After proper notice and hearing, the superintendent may order the delivery of appropriate care based on the facts and evidence contained in the record of a specific case, in addition to any other order he deems necessary and appropriate.~~

~~S. General Requirements for Independent Utilization Review Boards.~~

~~(1) Each time the superintendent accepts a request for external review for processing, he or she shall appoint a 3-member IURB to conduct an external review pursuant to t[sic]13 NMAC 10.13.15.18.5 [now Paragraph (5) of Subsection R of 13.10.13.15 NMAC]. The IURB shall consist of two physicians who are licensed to practice medicine in the state of New Mexico, and one attorney with relevant expertise who is licensed to practice law in the state of New Mexico. The superintendent shall appoint the IURB members from a list of physicians and attorneys compiled and maintained by the department. The superintendent may consult with such appropriate professional societies, organizations, or associations as is necessary to develop and maintain the list of physicians and attorneys willing to serve on the IURB. Each IURB member shall serve on a voluntary basis without compensation.~~

~~(2) Prior to accepting appointment by the superintendent, each potential iurb member shall provide to the superintendent a list identifying all health care insurers, MHCPs, health care facilities and other health providers with whom the potential IURB member maintains any health related business arrangements. The list shall include a brief description of the nature of any such arrangement. Each potential IURB member shall also disclose to the superintendent any other potential conflict of interest that may arise in hearing a particular case, including any relationship to the enrollee or to MHCP or health professionals involved in a particular case.~~

~~(3) Upon receipt of any request for an external review under 13 NMAC 10.13.15.18.3 [now Paragraph (3) of Subsection R of 13.10.13.15 NMAC], the superintendent shall assign the grievance to an IURB. The superintendent reserves the right to deny any assignment to any potential IURB member if, in his or her determination, such an assignment would result in a conflict of interest or would otherwise create an appearance of impropriety. In reaching such a determination, the superintendent shall take into consideration information submitted by potential IURB members pursuant to 13 NMAC 10.13.15.19.2 [now Paragraph (2) of Subsection S of 13.10.13.15 NMAC].~~

~~T. The MHCP shall maintain a record of all grievances, and shall submit the record to the superintendent in its annual report. The record shall include at least the following:~~

~~(1) Total number of grievances and utilization management appeals filed within the last year, categorized by cause and disposition;~~

~~(2) Average length of time for resolution of each complaint and utilization management appeal by cause or category.~~

~~U. Liability of IURB members. The parties at each IURB hearing shall state on the record that IURB members appointed by the superintendent to serve on the IURB shall be held harmless from civil liability for all communications, findings, opinions, and conclusions made in the course and scope of the duties assigned to the IURB.~~] **[RESERVED]**

[3/16/98; 6/30/98; 12/1/98; 13.10.13.15 NMAC - Rn, 13 NMAC 10.13.15 & Repealed, 4/30/2007]

13.10.13.16 [~~REVIEW OF COMPLAINTS BY THE SUPERINTENDENT:~~

~~A. Complaints: Any person, group, association, corporation, or other entity may file a written complaint with the superintendent regarding a MHCP's compliance with this rule. A complaint shall state the grounds and pertinent underlying facts, the names of all relevant persons involved, the status of all appropriate internal grievance and appeals procedures and whether those procedures have been exhausted. If the complainant has not exhausted the MHCP's internal grievance procedures, a statement about why he or she has chosen to appeal directly to the superintendent shall be included.~~

~~B. Investigations: The superintendent may initiate investigations when, based on a report, a complaint, or any other information, he or she has reason to believe that an entity subject to this rule is not in compliance with its provisions. The superintendent will notify the entity in writing when an investigation has been initiated, and will include in such a notice a full statement of the pertinent facts, the matters being investigated, and a statement that the entity may submit a written report concerning these matters to the superintendent within 30 days from the date of the notice. The superintendent will obtain any information he or she considers necessary, and may employ site visits, public hearings, or any other procedures he or she considers appropriate.~~] **[RESERVED]**

[3/16/97; 13.10.13.16 NMAC - Rn, 13 NMAC 10.13.16 & Repealed, 4/30/2007]

13.10.13.19 U T I L I Z A T I O N MANAGEMENT:

A. Utilization management program: The health care insurer through its MHCP shall establish and implement a comprehensive utilization management program to monitor access to and appropriate utilization of health care services. The program shall be under the direction of a medical director responsible for the medical services provided by the MHCP in New Mexico and who is a licensed physician in New Mexico, and shall be based on a written plan that is reviewed at least annually. At a minimum,

the plan shall identify the following:

(1) scope of utilization management activities;

(2) procedures to evaluate clinical necessity, access, appropriateness, and efficiency of services;

(3) mechanisms to detect underutilization and overutilization;

(4) clinical review criteria and protocols used in decision-making;

(5) mechanisms to ensure consistent application of review criteria and uniform decisions;

(6) development of outcome and process measures for evaluating the utilization management program; and

(7) A mechanism to evaluate member and provider satisfaction with the complaint and appeals systems set forth at [~~13 NMAC 10.13.15~~] 13.10.17 NMAC. Such evaluation shall be coordinated with the performance monitoring activities conducted pursuant to the continuous quality improvement program set forth in 13.10.13.20 NMAC.

B. Utilization management determinations shall be based on written clinical criteria and protocols developed with involvement from practicing physicians and other health professionals and providers within the MHCP's network. These criteria and protocols shall be periodically reviewed and updated, and shall, with the exception of internal or proprietary quantitative thresholds for utilization management, be readily available, upon request, to affected providers and enrollees. The MHCP shall have the burden of showing that information requested by affected providers or enrollees is in fact proprietary. Nothing in this section shall be construed to prevent a MHCP from incorporating into its clinical protocols criteria from outside sources.

C. Utilization management staff availability:

(1) A registered professional nurse or physician shall be immediately available by telephone seven days a week, 24 hours a day, to render utilization management determinations for providers.

(2) The MHCP shall provide all enrollees and providers with a toll-free telephone number by which to contact utilization management staff on at least a five-day, 40 hours a week basis. The MHCP may provide a separate telephone number for enrollees and for providers.

(3) All enrollees must have immediate telephone access seven days a week, 24 hours a day, to their primary care physician or the physician's authorized on-call back-up provider. When these providers are unavailable, a registered nurse or physician on the utilization management staff must be available to respond to inquiries concerning emergency or urgent care.

D. Utilization management determinations:

(1) All determinations to authorize an admission, service, procedure or extension of stay shall be rendered by either a physician, registered professional nurse, or other qualified health professional.

(2) All determinations to deny or limit an admission, service, procedure or extension of stay shall be rendered by a physician, either after application of uniform criteria established by the plan in consultation with specialists acting within the scope of their license or after consultation with specialists acting within the scope of their license. The physician shall be under the clinical direction of the medical director responsible for medical services provided to the MHCP's New Mexico enrollees. Such determinations shall be made in accordance with clinical and medically necessary criteria developed pursuant to Subsection A of 13.10.13.19 NMAC and the evidence of coverage.

(3) All determinations shall be made on a timely basis as required by the exigencies of the situation and in accordance with sound medical principles, which, in any event, shall not exceed 24 hours for emergency care and seven days for all other determinations. If the MHCP is unable to complete a referral within ten days due to unforeseen circumstances, the MHCP shall inform the enrollee in writing about the reasons for the delay and when a decision may be expected.

(4) A MHCP may not retroactively deny reimbursement for a covered service provided to an enrollee by a provider who relied upon the verbal or written authorization of the MHCP or its agents prior to providing the service to the enrollee, except in those cases where there was material misrepresentation or fraud. Retroactive reimbursement for a covered service shall not be denied when the enrollee provides authorization information, such as a MHCP referral number, directly to the provider, except in those cases where there was material misrepresentation or fraud.

(5) An enrollee must receive a written notice of all determinations to deny coverage or authorization for health care services, which shall contain the reasons why coverage or authorization was denied, and which shall be subject to review in accordance with the specific grievance procedures outlined in [~~13 NMAC 10.13.15~~] 13.10.17 NMAC. The written notice shall advise the enrollee that review of the MHCP's denial of coverage or authorization is available. In addition, the notice shall describe the procedures necessary for commencing [~~a stage 1~~] an internal review as outlined in [~~13 NMAC 10.13.15~~] 13.10.17 NMAC.

E. **Accreditation by nationally recognized accrediting entity.** Nothing in this section shall prohibit a MHCP from submitting accreditation by a nationally recognized accrediting entity as evidence of compliance with the requirements of this section. In those instances where a MHCP seeks to meet the requirements of this section through accreditation by a private accrediting entity, the MHCP shall submit to the [~~department~~] division the following information: 1) current standards of the private accrediting entity in order to demonstrate that the entity's standards meet or exceed the requirements of this rule; 2) documentation from the private accrediting entity showing that the MHCP has been accredited by the entity; and 3) a summary of the data and information that was presented to the private accrediting entity by the MHCP and upon which accreditation of the MHCP was based. A MHCP accredited by the private accrediting entity that has submitted all of the requisite information to the [~~Department~~] division may then be deemed by the superintendent to have met the requirements of the relevant provisions of this section where comparable standards exist, provided that the private accrediting entity from which the MHCP obtained accreditation is recognized and approved by the superintendent.

[3/16/97, 6/30/98; 13.10.13.19 NMAC - Rn & A, 13 NMAC 10.13.19, 4/30/2007]

13.10.13.20 CONTINUOUS QUALITY IMPROVEMENT:

A. Under the direction of a medical director or his or her designated physician, the MHCP shall have a system-wide continuous quality improvement program to monitor the quality and appropriateness of care and services provided to enrollees. This program shall be based on a written plan which is reviewed at least annually and revised as necessary. The plan shall describe at least:

(1) the scope and purpose of the program;

(2) the organizational structure of quality improvement activities;

(3) duties and responsibilities of the medical director and/or designated physician responsible for continuous quality improvement activities;

(4) contractual arrangements, where appropriate, for delegation of quality improvement activities;

(5) confidentiality policies and procedures;

(6) specification of standards of care, criteria and procedures for the assessment of the quality of services provided and the adequacy and appropriateness of health care resources utilized;

(7) a system of ongoing evaluation activities, including individual case

reviews as well as pattern analysis;

(8) a system of focused evaluation activities, particularly for frequently performed and/or highly specialized procedures;

(9) a system for monitoring random enrollee satisfaction and network provider's response and feedback on MHCP operations;

(10) a system for verification of providers' credentials, recertification, performance reviews and for obtaining information about any disciplinary action against a provider available from any state licensing board applicable to the provider;

(11) the procedures for conducting peer review activities, which shall include providers within the same discipline and area of clinical practice;

(12) a system for evaluation of the effectiveness of the continuous quality improvement program.

B. The board of directors or other management body of the MHCP shall be kept apprised of continuous quality improvement activities and be provided at least annually with regular written reports from the program delineating quality improvements, performance measures used and their results, and demonstrated improvements in clinical and service quality.

C. There shall be a multidisciplinary continuous quality improvement committee responsible for the implementation and operations of the program. The structure of the committee shall include representation from the medical, nursing and administrative staff, with substantial involvement of the medical director of the MHCP.

D. The program shall monitor the availability, accessibility, continuity and quality of care on an ongoing basis. Indicators for evaluating the quality of health care services provided by all participating providers shall be identified and established and may include:

(1) a mechanism for monitoring patient appointment and triage procedures, discharge planning services, linkage between all modes and levels of care and appropriateness of specific diagnostic and therapeutic procedures, as selected by the continuous quality improvement program;

(2) a mechanism for evaluating all providers of care that is supplemental to each provider's quality improvement system;

(3) a system to monitor provider and enrollee access to utilization management services, including, at a minimum, waiting times to respond to phone requests for service authorization, enrollee urgent care inquiries, and other services required by this rule.

E. The MHCP shall follow up on findings from the program to assure that effective corrective actions have been taken, including, at a minimum, policy revisions, procedural changes and implementation of educational activities for enrollees and providers.

F. Continuous quality improvement activities shall be coordinated with other performance monitoring activities including utilization management, risk management, and monitoring of enrollee and provider complaints.

G. The MHCP shall maintain documentation of the quality improvement program in a confidential manner. This documentation shall be available to the superintendent, shall be submitted as part of the health care insurer's annual report to the superintendent, and shall include:

(1) minutes of quality improvement committee meetings;

(2) records of evaluation activities, performance measures, quality indicators and corrective plans and their results or outcomes.

H. **External quality audit**:

(1) Upon request by the superintendent, each MHCP shall have an external quality audit conducted by an IQRO approved by the [~~department~~] division, and shall submit proof to the superintendent that such an audit and report has been completed.

(2) The report must describe in detail the MHCP's conformance to performance standards established by the IQRO, other national standard-setting bodies for MHCPs, and the standards set out in this rule. The report shall also describe in detail any corrective actions proposed and/or undertaken and approved by the IQRO. The report shall be submitted to the [~~department~~] division within 60 days of its receipt in final form by the MHCP.

(3) The superintendent may grant a MHCP a deferral of the above requirement for an external quality audit for a 12-month period if it is in the initial three years of start-up operations.

I. **Performance and outcome measures**.

(1) The [~~department~~] division may develop a performance and outcome measurement system for monitoring the quality of care provided to MHCP enrollees. The data collected through this system may be used by the [~~department~~] division to:

(a) assist MHCPs and their providers in quality improvement efforts;

(b) provide the [~~department~~] division with information on the performance of MHCPs for regulatory oversight;

(c) support efforts to inform consumers about MHCP performance;

(d) promote the standardization of data reporting by MHCPs and providers; and for

(e) any other purpose consistent with the policies and provisions of this rule and the Insurance Code.

(2) The performance and outcome measures may include population-based and patient-centered indicators of quality of care, appropriateness, access, utilization, and satisfaction. To minimize costs to health care insurers, MHCPs, providers, and the [~~department~~] division, performance measures will incorporate, when possible, data routinely collected or available to the [~~department~~] division from other sources. Data for these performance measures may include but not be limited to the following:

(a) indicator data collected by MHCPs from chart reviews and administrative data bases;

(b) enrollee and patient satisfaction surveys;

(c) provider surveys;

(d) all reports submitted by MHCPs to the superintendent as required by this rule;

(e) data collected by the [~~department~~] division for administrative, epidemiological and other purposes, such as the state cancer registry, vital records, and hospital records.

(3) MHCPs shall submit such performance and outcome data as the [~~department~~] division may request from time to time.

(4) The [~~department~~] division shall provide each MHCP an opportunity to comment on the compilation and interpretation of the data before its release to consumers.

(5) The [~~department~~] division may conduct or arrange for periodic enrollee satisfaction surveys. Upon request by the superintendent, the MHCP shall provide the [~~department~~] division with the enrollee mailing list to be used to select samples of the MHCP's membership for the surveys. Upon request by the superintendent, the MHCP shall also provide the [~~department~~] division with a mailing list of former enrollees who are no longer covered by the MHCP, which the [~~department~~] division may use to select samples of the MHCP's former enrollees for surveys.

(6) The [~~department~~] division shall ensure the confidentiality of patient specific information.

(7) The [~~department~~] division shall take all necessary measures to reduce duplicative reporting of information to state agencies. Any performance and outcome measurement system developed by the [~~department~~] division shall not be duplicative of the health information system created by the Health Information System Act,

Chapter 24, Article 14A NMSA 1978, and implemented by the New Mexico health policy commission.

(8) In developing a performance and outcome measurement system, the [~~department~~] division shall take into consideration data reporting standards of nationally recognized accrediting entities, such as, for example, the health plan employer data and information set (HEDIS), and shall attempt to avoid duplication of such reporting standards, so that a MHCP may, where possible, submit the same data to the [~~department~~] division that the MHCP submits to a private accrediting entity.

J. **Accreditation by nationally recognized accrediting entity**: Nothing in this section shall prohibit a MHCP from submitting accreditation by a nationally recognized accrediting entity as evidence of compliance with the requirements of this section. In those instances where a MHCP seeks to meet the requirements of this section through accreditation by a private accrediting entity, the MHCP shall submit to the [~~department~~] division the following information: 1) current standards of the private accrediting entity in order to demonstrate that the entity's standards meet or exceed the requirements of this rule; 2) documentation from the private accrediting entity showing that the MHCP has been accredited by the entity; and 3) a summary of the data and information that was presented to the private accrediting entity by the MHCP and upon which accreditation of the MHCP was based. A MHCP accredited by the private accrediting entity that has submitted all of the requisite information to the [~~department~~] division may then be deemed by the superintendent to have met the requirements of the relevant provisions of this section where comparable standards exist, provided that the private accrediting entity from which the MHCP obtained accreditation is recognized and approved by the superintendent.

[3/16/97, 6/30/98; 13.10.13.20 NMAC - Rn & A, 13 NMAC 10.13.20, 4/30/2007]

13.10.13.25 CONTRACTS WITH PROVIDERS:

A. A MHCP shall, either directly or indirectly, enter into contracts with participating providers and health care facilities through which health care services are provided on a recurring basis to its enrollees. The MHCP shall file an annual certificate with the superintendent certifying that all provider contracts and contracts with health care facilities through which health care services are being provided on a recurring basis meet the criteria of this section.

B. Each contract shall contain a description of the method by which the provider or health care facility will be notified of the specific health care services for which the provider or health care facilities will be responsible, including any limitations or conditions on such services.

C. Each contract shall contain the specific hold harmless provision specifying protection of enrollees set forth as follows: "Provider/health care facility agrees that in no event, including but not limited to nonpayment by the health insuring corporation, insolvency of the health insuring corporation, or breach of this agreement, shall provider/health care facility bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a subscriber, enrollee, person to whom health care services have been provided, or person acting on behalf of the covered enrollee, for health care services provided pursuant to this agreement. This does not prohibit provider/health care facility from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the health insuring corporation or its successor."

D. Each contract shall contain a provision clearly stating the rights and responsibilities of the MHCP, and of the contracted providers and health care facilities, with respect to administrative policies and programs, including, but not limited to, payment systems, utilization review, quality assessment and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs.

E. Each contract shall contain a provision regarding the availability and confidentiality of those health records maintained by providers and health care facilities to monitor and evaluate the quality of care, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the necessity of an appropriateness of health care services provided to enrollees. The provision shall include terms requiring the provider or health care facility to make these health records available to appropriate state and federal authorities involved in assessing the quality of care or in investigating the grievances or complaints of enrollees, and requiring the provider or health care facility to comply with applicable state and federal laws related to the confidentiality of medical or health records.

F. Each contract shall provide that contractual rights and responsibilities may not be assigned or delegated by the provider or health care facility without the prior written consent of the health care insurer.

G. Each contract shall contain a provision requiring the provider or health care facility to maintain adequate professional liability and malpractice insurance. The provision shall also require the provider or health care facility to notify the health care insurer not more than ten days after the provider's or health care facility's receipt of notice of any reduction or cancellation of such coverage.

H. Each contract shall require the provider or health care facility to observe, protect, and promote the rights of enrollees as patients.

I. Each contract shall require the provider or health care facility to provide health care services without discrimination on the basis of a patient's participation in the health care plan, age, gender, ethnicity, religion, sexual orientation, health status, or disability, and without regard to the source of payments made for health care services rendered to a patient. This requirement shall not apply to circumstances when the provider or health care facility appropriately does not render services due to limitations arising from the provider's or health care facility's lack of training, experience, or skill, or due to licensing restrictions.

J. Each contract shall contain a provision detailing the specifics of any obligation on the provider or health care facility to provide, or to arrange for the provision of, covered health care services twenty-four hours per day, seven days per week.

K. Each contract shall set forth procedures for the resolution of disputes arising out of the contract.

L. Each contract shall state that the hold harmless provision required by Subsection C of 13.10.13.25 NMAC shall survive the termination of the contract regardless of the reason for the termination, including the insolvency of the health care insurer or MHCP.

M. Each contract shall provide that those terms used in the contract and that are defined by New Mexico statutes and [~~department~~] division regulations will be used in the contract in a manner consistent with any definitions contained in said laws or regulations.

N. A health care insurer or MHCP is prohibited from including the following provisions in any of its contracts with providers or health care facilities:

(1) offer an inducement, financial or otherwise, to provide less than medically necessary services to a covered enrollee;

(2) penalize a provider or health care facility that assists an enrollee to seek a reconsideration of the health care insurer's or MHCP's decision to deny or limit benefits to the enrollee;

(3) prohibit a participating provider from discussing treatment options

with covered persons irrespective of the health care insurer's or MHCP's position on treatment options, or from advocating on behalf of a patient or patients within the utilization review or grievance processes established by the health care insurer or MHCP or a person contracting with the health care insurer or MHCP;

(4) prohibit a participating provider from using disparaging language or making disparaging comments when referring to the health care insurer or MHCP.

O. Each contract shall provide that a MHCP failing to pay a provider or failing to pay an enrollee for out of pocket covered expenses within forty-five days after a clean claim has been received by the MHCP shall be liable for the amount due and unpaid with interest on that amount at the rate of one and one half times the rate established by a bulletin entered by the superintendent in January of each calendar year. For the purposes of this section, "clean claim" means a manually or electronically submitted claim that contains all the required data elements necessary for accurate adjudication without the need for additional information from outside of the MHCP's system and contains no deficiency or impropriety, including lack of substantiating documentation currently required by the MHCP, or particular circumstances requiring special treatment that prevents timely payment from being made by the MHCP.

P. Except for the access requirements contained in [~~10 NMAC 10.13.11~~] 13.10.13.11 NMAC, nothing contained in this rule should be construed to either prohibit or limit a MHCP or health care insurer from entering into contracts with qualified health care professionals other than allopathic physicians to provide primary care to enrollees, provided that the health care professional is acting within his or her scope of practice as defined under the relevant state licensing law.

[3/16/97; 6/30/98; 13.10.13.25 NMAC - Rn & A, 13 NMAC 10.13.25, 4/30/2007]

13.10.13.29 CULTURAL AND LINGUISTIC DIVERSITY: The MHCP must ensure that information and services are available in languages other than English, that services area provided in a manner that takes into account cultural aspects of the enrollee population, and that accommodations are provided for enrollees with disability. Each MHCP shall develop, implement, and maintain a plan that reasonably addresses the cultural and linguistic diversity of its enrollee population.

A. On or before December 15, 1998, those MHCPs currently doing business in New Mexico shall submit to the superintendent for approval a plan of how the MHCP will address the cultural and linguistic diversity of its enrollee population. At a minimum, the plan shall address:

(1) how the MHCP will identify the language needs of enrollees;

(2) measures to be taken to ensure access for limited-English-proficient (LEP) enrollees in both administrative and health care encounters with the plan and its providers;

(3) steps the MHCP will take to ensure availability of adequate interpretation services within its network, which shall include a description of specific contracts or other arrangements for interpretation and identification of interpreters for the deaf;

(4) whether interpreting services are available to enrollees on a 24-hour basis for emergency care;

(5) whether linguistic and cultural needs is explicitly addressed in the MHCP's continuous quality improvement program;

(6) how the MHCP will conduct outreach to ensure that enrollees with particular cultural and linguistic needs are identified by the MHCP and made aware of the services available to them to address their needs;

(7) any guidelines or training regarding cultural and linguistic needs of enrollees that the MHCP will utilize with its own staff and providers within its network;

(8) the extent to which the MHCP contracts with community clinics and other local providers that offer linguistic and culturally appropriate services to enrollees in their areas; and

(9) physical accessibility to persons with disabilities of MHCP information and administrative services as well as the provider network.

B. A MHCP new to this state shall submit a plan for addressing [~~and~~] linguistic diversity to the superintendent as part of its application for licensure. The plan shall address all of the factors listed Subsection A of 13.10.13.29 NMAC.

C. The superintendent shall approve or reject a plan submitted by a MHCP within 45 days after the plan is submitted to the superintendent. If the superintendent rejects a plan submitted by a MHCP, the superintendent shall state in writing in a letter addressed to the MHCP the specific grounds for rejection.

[3/16/97; 6/30/98; N, 13 NMAC 10.13.29, 12/1/98; 13.10.13.29 NMAC - Rn & A, 13 NMAC 10.13.29, 4/30/2007]

13.10.13.30 CONSUMER ASSISTANCE:

A. Consumer assistance office: Each MHCP shall establish and adequately staff a consumer assistance office. On or before December 15, 1998, those MHCPs currently doing business in New Mexico shall submit to the superintendent for approval a plan of how the MHCP's consumer assistance office will be organized and established. At a minimum, the plan shall address:

(1) the staffing of the consumer assistance office, including whether the planned hours and level of staffing are sufficient for the numbers and types of enrollees served by the MHCP;

(2) the MHCP's arrangements to meet the needs of enrollees with special needs;

(3) how the consumer assistance staff will be trained;

(4) how the independence of staff assigned to assist consumers is assured; and

(5) whether staff will have the authority to assist consumers in filing and pursuing a grievance or appeal.

B. A MHCP new to this state shall submit a plan for establishing a consumer assistance office to the superintendent as part of its application for licensure.

C. The superintendent shall approve or reject a plan submitted by a MHCP within 45 days after the plan is submitted to the superintendent. If the superintendent rejects a plan submitted by a MHCP, the superintendent shall state in writing in a letter addressed to the MHCP the specific grounds for rejection.

D. Consumer advisory board: Each MHCP shall establish and maintain a consumer advisory board.

(1) The consumer advisory board shall meet at least quarterly and shall advise the MHCP about the MHCP's general operations from the perspective of the enrollee as a consumer of health care.

(2) The consumer advisory board shall review the operations of and be advisory to the MHCP's consumer assistance office.

(3) All members of the consumer advisory board shall be current enrollees of the MHCP, employees of groups which subscribe to the MHCP's of benefits, or be representatives consumer organizations that represent the interests of health care consumers. No member of the consumer advisory board shall be an employee of the MHCP, nor shall the board members' immediate family be employees of the MHCP.

(4) The MHCP shall implement procedures whereby, when specific recommendations are made by the advisory board, representatives of the MHCP with responsibility for the substantive areas addressed in the recommendation will consider the matters raised in the recommendation and timely respond to the advisory board.

(5) The MHCP shall inform enrollees of the advisory board's existence

and role in the operation of the MHCP. Upon contract renewal, the MHCP must [~~may~~] provide such information in the evidence of coverage. Prior to contract renewal, the MHCP may provide such information in a separate mailing or in the next MHCP newsletter issued after the effective date of this provision.

[3/16/97; 13 NMAC 10.13.30 - N, 12/1/98; 13.10.13.30 NMAC - Rn & A, 13 NMAC 10.13.30, 4/30/2007]

NEW MEXICO TAXATION AND REVENUE DEPARTMENT

This is an amendment to 3.1.4 NMAC, Section 13, effective 4/30/07.

3.1.4.13 **REPORTING ACCORDING TO BUSINESS LOCATION**

A. **REPORTING ACCORDING TO BUSINESS LOCATION - GENERAL:**

(1) Any person maintaining more than one place of business in New Mexico and reporting under one identification number is required to report the taxable gross receipts for each location on a single CRS-1 form. Receipts from locations in each municipality or in each county outside a municipality where a place or places of business are maintained must be indicated separately on the CRS-1 form.

(2) A person who maintains multiple places of business in a single municipality or multiple places of business not within a municipality but within a single county and who reports under one identification number is required to combine the taxable gross receipts from these places of business, indicating the total taxable gross receipts derived from all locations in each municipality or county on the CRS-1 form.

(3) For persons engaged in the construction business, "place of business" includes each place where construction is performed.

(4) The "place of business" of a person who has no other place of business in New Mexico, but who has sales personnel who reside in New Mexico, includes each place where such personnel reside. Such persons are required to report gross receipts in the manner provided in Paragraphs (1) and (2) of Subsection A of 3.1.4.13 NMAC. The place of business of a person who has no other place of business and does not have sales personnel who reside in New Mexico but who does have service technicians who perform service calls in New Mexico is "out of state", whether the service technicians live in New Mexico or elsewhere. For the purposes of Paragraph (4) of Subsection A of 3.1.4.13 NMAC, a "service technician" is an employee whose primary work responsibility is the repair, servicing and maintenance of the products sold or serviced by the employer and whose sales activities are at most incidental.

(5) A person, other than an itinerant peddler, who is liable for the gross receipts tax and who has no "place of business" or resident sales personnel or other employees such as service technicians in New Mexico is required to indicate on the CRS-1 form that the business location is "out-of-state".

(6) A person is required to report receipts for the location where the place of business is maintained even though the sale or delivery of goods or services was not performed at or from the place of business, except as provided in Subsection J of this section. It should be noted, however, that each construction site, as indicated in Paragraph (3) of Subsection A of 3.1.4.13 NMAC, is a "place of business" for this purpose.

(7) If a person has more than one place of business in New Mexico, the department will accept, on audit, this person's method of crediting sales to each place of business, provided the method of crediting is in accordance with the person's regular accounting practice and contains no obvious distortion.

(8) Example 1: The X company maintains its only place of business in Roswell, but sends its sales personnel to different cities in New Mexico to solicit sales and take orders. X is not required to report its gross receipts for each municipality in which its sales personnel are operating. X reports its gross receipts only for Roswell because its sole place of business is Roswell.

(9) Example 2: The Z company maintains its only place of business in Grants. It makes deliveries in its own trucks to customers in various other cities within New Mexico. Z is not required to report its gross receipts for each municipality in which it makes deliveries. Z reports its gross receipts only for Grants. It is not maintaining a place of business in municipalities outside Grants solely because of its deliveries.

(10) Example 3: The W furniture company maintains its only office and showroom inside the city limits of Carrizozo. W's furniture warehouse is located outside the Carrizozo city limits. Furniture sold by W is, for the most part, delivered from its warehouse. W's "place of business" is in Carrizozo and it must report all its gross receipts for that municipality, regardless of the location of its warehouse.

(11) Example 4: The X appliance company maintains offices and showrooms in both Truth or Consequences and Las Cruces. The Truth or Consequences place of business initiates a sale of a refrigerator. The refrigerator is delivered from stock held in the Las Cruces place of business. X's place of business to which it credits the sale will be accepted on audit, if the crediting is in accordance with X's method of crediting sales in its regular accounting practice and contains no obvious distortion. If X credits the sale to its Truth or Consequences place of business, the department will accept Truth or Consequences as the location of the sale. The same result will occur if X credits the sale to its Las Cruces place of business.

B. **REPORTING ACCORDING TO BUSINESS LOCATION - UTILITIES:**

(1) Each municipality and the portion of each county outside a municipality in which customers of a utility are located constitute separate places of business. The physical location of the customer's premises or other place to which the utility's product or service is delivered to the customer is a business location of the utility.

(2) The department will accept, on audit, a utility's method of crediting its sales to its places of business, provided the method of crediting is based on the location of its customers as business locations and the method of crediting contains no obvious distortion.

(3) For the purposes of 3.1.4.13 NMAC, "utility" means a public utility or any other person selling and delivering or causing to be delivered to the customer's residence or place of business water via pipeline, electricity, natural gas or propane, butane, heating oil or similar fuel or providing cable television service, telephone service or internet access service to the customer's residence or place of business.

C. **REPORTING BY PERSONS ENGAGED IN THE LEASING BUSINESS:** A person from out of state who is engaged in the business of leasing as defined in Subsection E of Section 7-9-3 NMSA 1978 and who has no place of business or resident sales personnel in New Mexico is required to indicate "out-of-state" on the CRS-1 report form and to calculate gross receipts tax due using the tax rate for the state. An out-of-state person engaged in the business of leasing who has a place of business or resident sales personnel in New Mexico is required to report gross receipts for each municipality or area within a county outside of any municipalities in which the person maintains a place of business or resident sales personnel. An in-state person engaged in the business of leasing with more than one place of business is required to report gross receipts for each municipality or area within a county outside of any municipality in which the person maintains a place of business.

D. **REPORTING TAXABLE GROSS RECEIPTS BY A PERSON MAINTAINING A BUSINESS OUTSIDE THE BOUNDARIES OF A MUNICIPALITY ON LAND OWNED BY THAT MUNICIPALITY:** For the purpose of distribution of the amount provided in Section 7-1-6.4 NMSA 1978, persons maintaining a place of business outside the boundaries of a municipality on land owned by that municipality are required to report their gross receipts for that location. For the purpose of calculating the amount of state and local gross receipts tax due, such persons shall use the sum of the gross receipts tax rate for the state plus all applicable tax rates for county-imposed taxes administered at the same time and in the same manner as the gross receipts tax.

E. **ITINERANT PEDDLERS - TEMPORARY BUSINESS LOCATIONS:**

(1) An itinerant peddler is a person who sells from a nonreserved location chosen for temporary periods on a first-come, first-served basis. An itinerant peddler does no advertising or soliciting, has no one employed to sell and is not employed as a salesperson.

(2) An itinerant peddler shall report taxable gross receipts by the municipality or the area of a county outside any municipality where the peddler maintains a place of business. If the itinerant peddler sells from only one location, that location shall be the place of business. If an individual peddler has no set sales location, the place of business shall be the peddler's temporary or permanent residence within New Mexico.

(3) Example: X occasionally places a blanket on a sidewalk in a town wherever X can find space for the blanket and sells homemade pies. X is an itinerant peddler because the space is not reserved specifically for X, it is chosen for temporary periods, and X is not employed nor does X have employees. Additionally, because X cannot be expected to be found regularly carrying on business at the same sidewalk location every day, X's place of business, for reporting purposes, is X's residence.

(4) Any person who pays a fee to occupy a particular location or space for a determined period of time and who sells any item or performs any service at that location is not an itinerant peddler and shall report that location as a place of business.

(5) Example: X pays $50.00 to rent a space for a booth for two days during a festival. X is not an itinerant peddler because the space was assigned, and during the festival X could normally be expected to be found carrying on business at that place. X must therefore report the gross receipts from sales made during the festival to the location of the space.

(6) Any person who, in advance, advertises through print or broadcast media or otherwise represents to the public that the person will be at a particular location for a specified period of time and who sells property or performs service at that location shall report that location as a place of business.

(7) Example: X sells fish from a truck in a shopping center parking lot. X places an advertisement in the local paper informing the public where X will be located and the dates when X will sell fish at that location. X is not an itinerant peddler because X advertises and solicits business, and X can normally be expected to be found at that location during the time designated in the advertisement. The shopping center is X's place of business and X must report all activity occurring there to that location.

F. **OBVIOUS DISTORTION:** For purposes of 3.1.4.13 NMAC, obvious distortion shall be presumed whenever the method used to credit sales to a place of business treats similar transactions inconsistently. Any method which intentionally credits sales to a location with a lower combined tax rate primarily for the purpose of reducing the taxpayer's total tax liability shall be presumed to contain obvious distortion, shall not be allowed and may be the basis of establishing intent to evade or defeat tax under the provisions of Section 7-1-72 NMSA 1978.

G. **SPACE PROVIDED BY CLIENT CONSTITUTES BUSINESS LOCATION:**

(1) Except as provided otherwise in Paragraph (6) of Subsection G of 3.1.4.13 NMAC, any person performing a service who occupies space provided by the purchaser of the service being performed has established a business location if the following conditions are present:

(a) the space is occupied by the provider of the service for a period of six consecutive months or longer;

(b) the provider or employees of the provider of the service are expected, by the purchaser of the services or representatives of the purchaser, to be available at that location during established times; and

(c) critical elements of the service are performed at, managed or coordinated from the purchaser's location.

(2) The following indicia will be considered in determining if the above conditions are present:

(a) the provider of the service has assigned employees to the client's location as a condition of employment;

(b) telephone is assigned for the exclusive use by the service provider;

(c) the space has been designated for the use of the service provider;

(d) the space contains office furniture or equipment furnished by either the client or the service provider for the sole use of the service provider;

(e) the service provider is identified by business name on a sign located in or adjacent to the provided space;

(f) the client or other persons can expect to communicate, either in person or by telephone, with the service provider or employees or representatives of the service provider at the space provided by the client; and

(g) the contract between the client and the service provider requires the client to provide space to the service provider.

(3) Any person meeting the three conditions as evidenced by the listed indicia must report the receipts derived from the performance of the service at the client's location to the municipality or county in which the furnished space is located.

(4) Example 1: X has entered into a contract to perform research and development services for the army at a location on White Sands missile range within Doña Ana county. The term of the contract is one year and is renewable annually. X is required by the contract to assign employees to the project at White Sands missile base on a full-time basis. The assigned employees consider White Sands as their place of employment. The army furnishes X with office and shop space as well as furniture and equipment. The space is identified as X's location by a sign containing X's business name at the main entrance to the assigned space. A specific telephone number has been assigned for X's exclusive use during the term of the contract. X shall report the receipts from services performed at the White Sands location under this contract using Doña Ana county as the location of business for gross receipts tax purposes.

(5) Example 2: Y has entered into a maintenance contract with a state agency to maintain and repair computer equipment. The state agency provides storage facilities to Y for the storage of equipment and parts which will be used by Y in the maintenance and repair of computer equipment. Y's employees are present at the location of the state agency only when required to repair the computers. The agency contacts Y at Y's regular place of business to report equipment problems and to request necessary repairs. On receipt of a request from the agency, Y dispatches an employee to the agency's location to repair the equipment. The location of the state agency does not constitute a separate business location for Y. Y shall report its receipts from the state agency under this contract to the location where Y maintains a regular place of business.

(6) The provisions of Subsection

G of 3.1.4.13 NMAC do not apply when:

(a) the provider of the service is a co-employer or joint employer with the client of the employees at the client's location or has entered into a contract to provide temporary employees to work at the client's facilities under the client's supervision and control; and

(b) the provider of the service has no employees at the client's location other than employees described in Subparagraph (a) of Paragraph (6) of Subsection G of 3.1.4.13 NMAC above.

H. **REPORTING ACCORDING TO BUSINESS LOCATION - PERSONS SUBJECT TO INTERSTATE TELECOMMUNICATIONS GROSS RECEIPTS TAX ACT:**

(1) Each municipality and the portion of each county outside all municipalities in which customers of a person who is engaging in an interstate telecommunications business and who is subject to the interstate telecommunications gross receipts tax are located constitute separate places of business. Except for commercial mobile radio service as defined by 47 C.F.R. 20.3, the location of the person's customer is the location of the telephone sets, other receiving devices or other points of delivery of the interstate telecommunications service.

(2) The department will accept, on audit, the person's method of crediting its sales to its places of business, provided the method of crediting is based on the location of its customers as business locations and the method of crediting contains no obvious distortion.

(3) This version of Subsection H of 3.1.4.13 NMAC applies to all interstate telecommunications gross receipts tax returns due after January 1, 2000.

I. **REPORTING ACCORDING TO BUSINESS LOCATION - COMMERCIAL MOBILE RADIO SERVICE PROVIDERS:** For interstate telecommunications gross receipts tax returns due after January 1, 2000, each municipality and the portion of each county outside all municipalities in which customers of the provider of a commercial mobile radio service as defined by 47 C.F.R. 20.3 are located constitute separate places of business. With respect to the provision of commercial mobile radio service, the business location of a customer will be determined by the customer's service location. A customer's service location is determined first by the customer's billing address within the licensed service area. If the customer does not have a billing address within the licensed service area or if the customer's billing address is a post office box or mail-drop, then the customer's service location is the street or rural address of the customer's residence or business facility within that service area.

J. **TRANSACTIONS ON TRIBAL TERRITORY:** [~~The secretary may require~~] A person selling or delivering goods or performing services [~~to a tribal non-member~~] on the tribal land of a tribe or pueblo that has entered into a gross receipts tax cooperative agreement with the state of New Mexico pursuant to Section 9-11-12.1 NMSA 1978 is required to report those receipts based on the tribal location of the sale or delivery of the goods or performance of the service rather than the person's business location.

[3/5/70, 7/6/79, 11/20/79, 4/11/83, 11/5/85, 1/4/88, 8/22/88, 12/29/89, 8/15/90, 9/3/92, 2/22/95, 10/31/96, 7/30/99, 10/29/99; 3.1.4.13 NMAC - Rn & A, 3 NMAC 1.4.13, 12/29/00; A, 12/30/03; A, 1/17/06; A, 4/30/07]

NEW MEXICO TAXATION AND REVENUE DEPARTMENT

This is an amendment to 3.1.7 NMAC, Section 13, effective 4/30/07.

3.1.7.13 **INFORMAL CONFERENCES:**

A. [~~The secretary may, in appropriate cases,~~] Upon the taxpayer's written request or the department's own initiative, the department will provide for an informal conference before setting a hearing on the protest. [~~Any~~] When requested, an informal conference will be scheduled at a time and place agreed to by both parties. The secretary may attend or designate a delegate to attend. Both parties may bring representatives of their own choosing to the conference, and both parties may bring any records or documents that are pertinent to the issues to be discussed. An informal conference will be vacated if the parties resolve the protest prior to the scheduled date.

B. The purpose of the informal conference is to discuss the facts and the legal issues. The result of an informal conference will usually be one of the following:

(1) an agreement that the taxpayer will withdraw all or part of the protest;

(2) an agreement that the department will abate all or part of the assessment protested, or will refund all or part of the amount of refund claimed;

(3) an agreement to enter into a closing agreement;

(4) an agreement that one or more issues will be litigated upon stipulated facts or a statement of the case;

(5) an agreement to schedule a formal hearing; or

(6) any combination of the above agreements.

C. The taxpayer or the department may be given the opportunity to provide more facts if the situation warrants. There is no statutory restriction on the number of informal conferences that may be scheduled with a taxpayer but, after the initial informal conference, additional informal conferences will be scheduled only if the secretary believes that the additional informal conferences will be useful in resolving the issues. In the event that the taxpayer fails to appear at the informal conference without reasonable notice to the secretary, the protest may be scheduled for a formal hearing without further opportunity for an informal conference.

[11/5/85, 8/15/90, 10/31/96; 3.1.7.13 NMAC - Rn & A, 3 NMAC 1.7.13, 1/15/01, A, 8/30/01; A, 4/30/07]

NEW MEXICO TAXATION AND REVENUE DEPARTMENT

This is an amendment to 3.1.8 NMAC, Section 8, effective 4/30/07.

3.1.8.8 **GENERAL RULES ON FORMAL HEARINGS:**

A. Formal hearings are held in Santa Fe. Hearings are not open to the public except upon request of the taxpayer. Taxpayers may appear at a hearing for themselves or be represented by a bona fide employee or an attorney licensed to practice in New Mexico, certified public accountant or registered public accountant.

B. Every party shall have the right of due notice, cross-examination, presentation of evidence, objection, motion, argument and all other rights essential to a fair hearing, including the right to discovery as provided in these rules.

C. An adverse party, or an officer, agent or employee thereof, and any witness who appears to be hostile, unwilling or evasive may be interrogated by leading questions and may also be contradicted and impeached by the party calling that person.

D. The parties may agree to, and the hearing officer may accept, the joint submission of stipulated facts relevant to the issue or issues. The hearing officer may order the parties to stipulate, subject to objections as to relevance or materiality, to uncontested facts and to exhibits. The hearing officer may also order the parties to stipulate to basic documents concerning the controversy, such as audit reports of the department, assessments issued by the department, returns and payments filed by the party taxpayers and correspondence between the parties, and to basic facts concerning the identity and business of a taxpayer, such as the taxpayer's business loca-

tions in New Mexico and elsewhere, the location of its business headquarters and, if applicable, the state of its incorporation or registration.

[7/19/67, 11/5/85, 8/15/90, 10/31/96; 3.1.8.8 NMAC - Rn, 3 NMAC 1.8.8, 1/15/01, A, 8/30/01; A, 4/30/07]

NEW MEXICO TAXATION AND REVENUE DEPARTMENT

This is an amendment to 3.2.10 NMAC, Section 8, effective 4/30/07.

3.2.10.8 **TANGIBLE PERSONAL PROPERTY ACQUIRED OUTSIDE NEW MEXICO FOR USE IN NEW MEXICO:**

A. Tangible personal property acquired as a result of a transaction outside New Mexico which would have been subject to the gross receipts tax had that transaction occurred in New Mexico is subject to the compensating tax if that tangible personal property is subsequently used in New Mexico. For compensating tax purposes, a transaction would have been "subject to the gross receipts tax" when the transaction would have been within New Mexico's taxing jurisdiction, the receipts from the transaction would have been defined as gross receipts, the receipts would not have been deductible or exempt and taxation by New Mexico would not be pre-empted by federal law.

B. Example 1: X, a New Mexico resident, purchases the furniture for a new house from an El Paso, Texas, merchant. X brings this furniture into New Mexico in X's truck and puts it in the house. If X had purchased the furniture in New Mexico, the transaction would have been subject to the gross receipts tax. Therefore, X is liable for compensating tax measured by the sale price of the furniture. However, X may take a credit of up to 5% of the sale price of the furniture against the compensating tax liability on this furniture for any sales tax which was paid in Texas on the purchase of the furniture. Also, X pays no separate tax if tax collected by the seller is shown on the invoice as the New Mexico compensating tax collected by the El Paso, Texas, merchant.

C. Example 2: G operates a carnival concession. G has purchased tangible personal property in Iowa, to be used as prizes for persons performing certain skills at the carnival concession. G is subject to the compensating tax on the value of the tangible personal property acquired in Iowa, which is used as prizes in New Mexico.

[~~D. Example 3: C, a corporation, buys a computer for use in its New Mexico office from an out-of-state mail order company. The mail order company charges no gross receipts, sales or compensating tax on the transaction. C is subject to the compensating tax on the value of the computer.~~]

[9/29/67, 12/5/69, 3/9/72, 11/20/72, 3/20/74, 7/26/76, 6/18/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 10/28/94, 11/15/96, 3.2.10.8 NMAC - Rn, 3 NMAC 2.7.8, 4/30/01; A, 4/30/07]

NEW MEXICO TAXATION AND REVENUE DEPARTMENT

This is an amendment to 3.2.239 NMAC, Section 9, effective 4/30/07.

3.2.239.9 **RECEIPTS NOT ELIGIBLE FOR DEDUCTION:**

[~~A. The deduction provided by Section 7-9-85 NMSA 1978 does not apply to the receipts of an organization derived from an unrelated trade or business as defined in Section 513 of the Internal Revenue Code.~~

~~B.~~] The deduction provided by Section 7-9-85 NMSA 1978 does not apply to the receipts from more than two (2) fundraising events during any calendar year.

[3/16/95, 11/15/96; 3.2.239.9 NMAC - Rn, 3 NMAC 2.85.9 & A, 6/14/01; A, 4/30/07]

End of Adopted Rules Section

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Other Material Related to Administrative Law

NEW MEXICO BOARD OF EXAMINERS FOR ARCHITECTS

New Mexico Board of Examiners for Architects

PO Box 509
Santa Fe, NM
505-982-2869

Regular Meeting

The New Mexico Board of Examiners for Architects will hold a regular open meeting of the Board in Santa Fe, New Mexico on Friday, May 4, 2007. The meeting will be held in the Conference Room of the Board office, #5 Calle Medico, Ste. C in Santa Fe beginning at 9:00 a.m. Disciplinary matters may also be discussed.

If you are an individual with a disability who is in need of a reader, amplifier, qualified sign language interpreter, or other form of auxiliary aid or service to attend or participate in the meeting, please contact the Board Office at 982-2869 at least one week prior to the meeting. Public documents, including the agenda and minutes can be provided in various accessible formats. Please contact the Board Office if a summary or other type of accessible format is needed.

End of Other Related Material Section

SUBMITTAL DEADLINES AND PUBLICATION DATES

2007

Volume XVIII	Submittal Deadline	Publication Date
Issue Number 1	January 2	January 16
Issue Number 2	January 17	January 31
Issue Number 3	February 1	February 14
Issue Number 4	February 15	February 28
Issue Number 5	March 1	March 15
Issue Number 6	March 16	March 30
Issue Number 7	April 2	April 16
Issue Number 8	April 17	April 30
Issue Number 9	May 1	May 15
Issue Number 10	May 16	May 31
Issue Number 11	June 1	June 14
Issue Number 12	June 15	June 29
Issue Number 13	July 2	July 16
Issue Number 14	July 17	July 31
Issue Number 15	August 1	August 15
Issue Number 16	August 16	August 30
Issue Number 17	August 31	September 14
Issue Number 18	September 17	September 28
Issue Number 19	October 1	October 15
Issue Number 20	October 16	October 31
Issue Number 21	November 1	November 15
Issue Number 22	November 16	November 30
Issue Number 23	December 3	December 14
Issue Number 24	December 17	December 31

The *New Mexico Register* is the official publication for all material relating to administrative law, such as notices of rule making, proposed rules, adopted rules, emergency rules, and other similar material. The Commission of Public Records, Administrative Law Division publishes the *New Mexico Register* twice a month pursuant to Section 14-4-7.1 NMSA 1978. For further subscription information, call 505-476-7907.