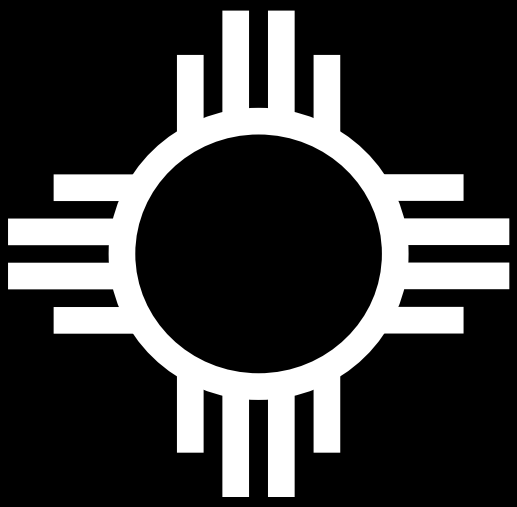
NEW MEXICO REGISTER



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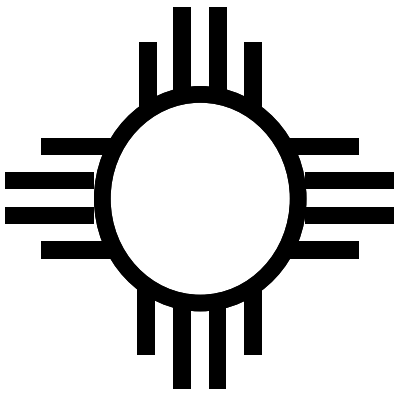

The official publication for all notices of rulemaking and filings of adopted, proposed and emergency rules in New Mexico

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2009

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New Mexico Register

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Effective Date and Validity of Rule Filings

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

A=*Amended*, E=*Emergency*, N=*New*, R=*Repealed*, Rn=*Renumbered*

Other Material Related to Administrative Law

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Notices of Rulemaking and Proposed Rules

ALBUQUERQUE-BERNALILLO COUNTY AIR QUALITY CONTROL BOARD

ALBUQUERQUE-BERNALILLO COUNTY AIR QUALITY CONTROL BOARD NOTICE OF HEARING

On August 12, 2009, at 5:30 PM, the Albuquerque-Bernalillo County Air Quality Control Board (Air Board) will hold a public hearing in the Vincent E. Griego Chambers located in the basement level of the Albuquerque-Bernalillo County Government Center, 400 Marquette Avenue NW, Albuquerque, NM. The hearing will address:

Proposal to amend 20.11.1 NMAC, *General Provisions*, and 20.11.8 NMAC, *Ambient Air Quality Standards*, and submit amendments to EPA as a revision to the SIP.

The AQD is proposing to amend 20.11.1 NMAC, *General Provisions,* and 20.11.8 NMAC, *Ambient Air Quality Standards,* for the following reasons:

1. The currently effective version of 20.11.1 NMAC, *General Provisions*, contains an error. Section 20.11.1.14 NMAC, *Interpretation*, belongs at 20.11.8.14 NMAC, and was left in 20.11.1 NMAC by mistake when these two rules were amended in 2004. The proposed amendment deletes this section.
2. The proposed amendments will align definition language codified at 20.11.1.7 NMAC with definition language in: 40 CFR Part 51.100(s); The New Mexico Air Quality Control Act; and a proposed new rule, 20.11.49 NMAC, *Excess Emissions*.
3. The proposed amendments will align local ambient air quality standards codified at 20.11.8.13 NMAC, with federal standards.
4. The proposed amendments will correct style and formatting.

Following the hearing, the Air Board will hold its regular monthly meeting during which the Air Board is expected to consider adopting the proposed revisions to 20.11.1 NMAC, *General Provisions*, and 20.11.8 NMAC, *Ambient Air Quality Standards.* The Air Board is the federally-delegated air quality authority for Albuquerque and Bernalillo County. Local delegation authorizes the Air Board to administer and enforce the Clean Air Act and the New Mexico Air Quality Control Act, and to require local air pollution sources to comply with air quality standards and regulations.

Hearings and meetings of the Air Board are open to the public and all interested persons are encouraged to participate. All persons who wish to testify regarding the subject of the hearing may do so at the hearing and will be given a reasonable opportunity to submit relevant evidence, data, views, and arguments, orally or in writing, to introduce exhibits and to examine witnesses in accordance with the Joint Air Quality Control Board Ordinances, Section 9-5-1-6 ROA 1994 and Bernalillo County Ordinance 94-5, Section 6, and 20.11.82 NMAC, *Rulemaking Procedures — Air Quality Control Board.*

Anyone intending to present technical testimony at this hearing is required by 20.11.82.20 NMAC to submit a written Notice Of Intent to testify (NOI) before 5:00pm on July 28, 2009, to: Attn: Hearing Clerk, Ms. Janice Amend, Albuquerque Environmental Health Department, P.O. Box 1293, Albuquerque, NM 87103, or, you may deliver your NOI to the Environmental Health Department, Room 3023, 400 Marquette Avenue NW. The NOI shall: 1. identify the person for whom the witness or witnesses will testify; 2. identify each technical witness the person intends to present and state the qualifications of that witness, including a description of their educational and work background; 3. summarize or include a copy of the direct testimony of each technical witness and state the anticipated duration of the testimony of that witness; 4. include the text of any recommended modifications to the proposed regulatory change; and 5. list and describe, or attach, all exhibits anticipated to be offered by that person at the hearing, including any proposed statement of reasons for adoption of rules.

In addition, written comments to be incorporated into the public record for this hearing should be received at the above P.O. box, or Environmental Health Department office, before 5:00 pm on August 5, 2009. Comments shall include the name and address of the individual or organization submitting the statement. Written comments may also be submitted electronically to jamend@cabq.gov and shall include the required name and address information. Interested persons may obtain a copy of the proposed regulation at the Environmental Health Department Office, or by contacting Ms. Janice Amend electronically at jamend@cabq.gov or by phone (505) 768-2601 or by downloading a copy from the City of Albuquerque Air Quality Division website http://www.cabq.gov/airquality/aqcb/public-review-drafts .

NOTICE FOR PERSON WITH DISABILITIES: If you have a disability and/or require special assistance please call (505) 768-2600 [Voice] and special assistance will be made available to you to review any public meeting documents, including agendas and minutes. TTY users call the New Mexico Relay at 1-800-659-8331 and special assistance will be made available to you to review any public meeting documents, including agendas and minutes.

NEW MEXICO ENVIRONMENT DEPARTMENT

NEW MEXICO ENVIRONMENT DEPARTMENT

NOTICE OF PUBLIC MEETING AND RULEMAKING HEARING

The New Mexico Environment Department ("NMED") will hold a public hearing on August 13, 2009 at 11:00 a.m. at the Air Quality Bureau, Room 240, 1301 Siler Road, Building B, Santa Fe, NM 87507. The purpose of the hearing is to consider the matter of amending 20.2.89 NMAC - Qualified Generating Facility Certification.

The proponent of this regulatory adoption and revision is the New Mexico Air Quality Bureau ("AQB").

NMED is proposing to amend this regulation to implement Senate Bill 237 from the 2009 legislative session (NMSA 1978 Section 7-9G-2). The proposed amended regulations add language that would allow NMED to evaluate solar photovoltaic and geothermal energy projects to determine whether they meet the requirements of a qualified energy facility in order to qualify for certain tax credits. NMED would then issue a certification for projects that qualify, and would deny certifications to projects that do not meet the requirements.

The proposed regulation may be reviewed during regular business hours at the NMED Air Quality Bureau office, 1301 Siler Road, Building B, Santa Fe, New Mexico 87507. A full text of NMED's amended regulation is available on NMED's web site at www.nmenv.state.nm.us/aqb, or by contacting Rita Bates at (505) 476-4304 or via e-mail to rita.bates@state.nm.us.

The hearing will be conducted in accordance with 20.1.9 NMAC (Rulemaking Procedures - Environment Department), the Department of Environment Act, Section 9-7A-6(D) NMSA 1978, the Air Quality Control Act Section, 74-2-6 NMSA 1978, and other applicable procedures.

All interested persons will be given reasonable opportunity at the hearing to comment on the proposed rule, orally or in writing.

If any person requires assistance, an interpreter or auxiliary aid to participate in this process, please contact Judy Bentley by October 20, 2009, at NMED, Personnel Service Bureau, Room N-4071, 1190 St. Francis Drive, P.O. Box 26110, Santa Fe, New Mexico, 87502. Ms. Bentley's telephone number is (505) 827-9872. TDY users please access Ms. Bentley's number through the New Mexico Relay Network at 1-800-659-8331.

The hearing officer may allow the record to remain open for a reasonable period of time following conclusion of the hearing for written submission of additional comments, documents, arguments and proposed statements of reasons. The hearing officer's determination shall be announced at the conclusion of the hearing. In considering whether to keep the record open, the hearing officer may consider the reasons why the material was not presented during the hearing, the significance of material to be submitted and the necessity for a prompt decision. If the record is kept open, the hearing officer shall determine and announce the subject(s) on which submittals will be allowed and the deadline for filing the submittals. The secretary shall render his final decision on the proposed regulatory changes within 60 days following close of the record.

NEW MEXICO HUMAN RIGHTS COMMISSION

On August 7, 2009, beginning at 9:00 a.m., at the University of New Mexico School of Law, Room 3402, Albuquerque, New Mexico, the Human Rights Commission will meet in Public Session. During the public meeting, the Human Rights Commission Rules, Title 9, Chapter 1, Part 1 will be opened for public comment and consideration for amendment.

A copy of the agenda or any of the affected rules can be obtained from *Pamela Lujan y Vigil, Court Administrator III, Department of Workforce Solutions, Human Rights Bureau, 1596 Pacheco St. Ste 103, Santa Fe, New Mexico 87505 or 505-827-6865.* This agenda is subject to change up to 24 hours prior to the meeting. Please contact the aforementioned office for updated information.

If you are an individual with a disability who is in need of a reader, amplifier, qualified sign language interpreter, or any other form of auxiliary aid or service to attend or participate in the hearing or meeting, please contact Mrs. Pamela Lujan y Vigil. Please contact Mrs. Lujan y Vigil at least 3 working days before the set meeting date.

NEW MEXICO PUBLIC EDUCATION DEPARTMENT

NEW MEXICO PUBLIC EDUCATION DEPARTMENT

NOTICE OF PROPOSED RULEMAKING

The Public Education Department ("Department") hereby gives notice that the Department will conduct public hearings in the State Capital Building, Room 317; 490 Old Santa Trail, Santa Fe, New Mexico 87501, on Friday, July 31, 2009, from 10:00 a.m. to 12:00 noon for Rule Number 6.10.8 Compulsory School Attendance and from 2:00 p.m. to 4:00 p.m. for Rule Number 6.29.4 English Language Arts. This hearing for Rule Number 6.29.4 is the result of changes made after the original rule making hearing on April 14, 2009. The Language Arts hearing resulted in public comments that changed the substance of the proposed rule.

The purpose of these public hearings will be to obtain input on the following rules:

Rule Number	Rule Name	Proposed Action
6.10.8 NMAC	Compulsory School Attendance	Amendment
6.29.4 NMAC	English Language Arts	New

Interested individuals may testify either at the public hearing or submit written comments regarding the proposed rulemaking for 6.10.8 NMAC to Kristine M. Meurer, Ph.D., Bureau Chief, School and Family Support Bureau, Public Education Department, 5600 Eagle Rock Ave, NE Room 201; Albuquerque, New Mexico 87113 (Kristine.Meurer@state.nm.us), fax (505) 222-4759. Written comments must be received no later than 5:00 p.m. on July 31, 2009.

Interested individuals may testify either at the public hearing or submit written comments regarding the proposed rulemaking for 6.29.4 NMAC to Ms. Carolann Gutierrez, Bureau Chief, Humanities Bureau, Public Education Department, Jerry Apodaca Education Building, 300 Don Gaspar, Santa Fe, New Mexico 87501-2786 (Carolann.Gutierrez@state.nm.us) fax (505) 476-0329. Written comments must be received no later than 5:00 p.m. on July 31, 2009.

Copies of the proposed rules may be accessed on the Department's website (http://ped.state.nm.us) or obtained from Kristine M. Meurer, Ph.D. Bureau Chief, School and Family Support Bureau, Public Education Department, 5600 Eagle Rock Ave, NE Room 201; Albuquerque, New Mexico 87113 (Kristine.Meurer@state.nm.us), phone (505) 222-4748 or fax (505) 222-4759. The proposed rules 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 Kristine M. Meurer Ph.D. as soon as possible. The Department requests at least ten (10) days advance notice to provide requested special accommodations.

NEW MEXICO PUBLIC EDUCATION DEPARTMENT

NEW MEXICO PUBLIC EDUCATION DEPARTMENT

NOTICE OF PROPOSED RULEMAKING

The Public Education Department ("Department") hereby gives notice that the Department will conduct a public hearing at Mabry Hall, Jerry Apodaca Building, 300 Don Gaspar,

Santa Fe, New Mexico 87501-2786, on Monday, August 3, 2009, from 10:00 a.m. to 12:00 p.m. The purpose of the public hearing will be to obtain input on the following rule:

Rule Number	Rule Name	Proposed Action
6.29.5 NMAC	New Mexico English Language Development Standards	Replace

Interested individuals may testify either at the public hearing or submit written comments regarding the proposed rulemaking to Dr. Gladys Herrera-Gurulé, State Director, Bilingual Multicultural Education Bureau, Public Education Department, Jerry Apodaca Education Building, 300 Don Gaspar, Santa Fe, New Mexico 87501-2786 (gladys.herrera-gurule@state.nm.us) (505)-827-6667 fax (505) 827-6563. The proposed rules will be made available at least thirty days prior to the hearing. Written comments must be received no later than 5:00 p.m. on August 3, 2009. However, submission of written comments as soon as possible is encouraged.

Copies of the proposed rule may be accessed on the Department's website (http://ped.state.nm.us) or obtained from Dr. Gladys Herrera-Gurulé, State Director, Bilingual Multicultural Education Bureau, Public Education Department, Jerry Apodaca Education Building, 300 Don Gaspar, Santa Fe, New Mexico 87501-2786 (gladys.herrera-gurule@state.nm.us) (505)-827-6667 fax (505) 827-6563.

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 Dr. Gladys Herrera-Gurulé as soon as possible. The Department requests at least ten (10) days advance notice to provide requested special accommodations.

NEW MEXICO PUBLIC REGULATION COMMISSION

INSURANCE DIVISION

BEFORE THE NEW MEXICO SUPERINTENDENT OF INSURANCE

IN THE MATTER OF PROPOSED 2010 MEDICARE SUPPLEMENT PLAN STANDARDS **DOCKET NO. 09-00216-IN**

NOTICE OF PROPOSED RULEMAKING, HEARING AND PROCEDURAL ORDER

NOTICE IS HEREBY GIVEN that the New Mexico Superintendent of Insurance ("Superintendent") pursuant to NMSA 1978, Section 59A-2-9, proposes to promulgate a rule entitled "2010 Medicare Supplement Plan Standards."The Superintendent, being otherwise fully advised, **FINDS and CONCLUDES THAT:**

1. The proposed regulation is based on a model regulation adopted by the NAIC in response to federal legislation under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) to section 1882 of the Social Security Act (the Act), which governs Medicare supplemental insurance.

2. The model regulation passed by the NAIC has been published in Vol. 74, No. 78 of the Federal Register, on April 24, 2009, as a notice of recognition by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services of its applicability to the MIPPA requirements, subject to CMS clarification as set forth in the Federal Register notice.

3. This proposed rulemaking, hearing and procedural order, which is also governed and authorized by state law, at Section 59A-24-4 NMSA, is intended to bring the state of New Mexico into compliance with the federal standards under MIPPA regarding Medicare supplement plans, and to allow the superintendent of insurance to preserve regulatory authority over the Medicare supplemental policies of coverage for the protection of New Mexico seniors.

COPIES OF PROPOSED RULEMAKING ARE AVAILABLE:

a. by downloading from the Public Regulation Commission's website, www.nmprc.state.nm.us, then clicking on the maroon-colored box labeled "Proposed Rules," scroll down to "Insurance," Docket No. 09-00216-IN, "2010 Medicare Supplement Plan Standards."

b. by sending a written request with the docket number, rule names, and rule numbers to the Public Regulation Commission's Docketing Office, P.O. Box 1269, Santa Fe, NM 87504-1269 along with a self-addressed envelope and a check for $1.25 made payable to the Public Regulation Commission to cover the cost of copying; or

c. for inspection and copying during regular business hours in the Public Regulation Commission's Docketing Office, Room 406, P.E.R.A. Building, corner of Paseo de Peralta and Old Santa Fe Trail, Santa Fe, NM.

COMMENTS ON RULEMAKING: The Superintendent requests written and oral comments from all interested persons and entities on the proposed rulemaking. All relevant and timely comments, including data, views, or arguments, will be considered by the Superintendent. In reaching his decision, the Superintendent may take into account information and ideas not contained in the comments, providing that such information or a writing containing the nature and source of such information is placed in the docket file, and provided that the fact of the Superintendent's reliance on such information is noted in the order the Superintendent ultimately issues.

IT IS THEREFORE ORDERED that this Notice of Hearing on Proposed Rulemaking and Procedural Order be issued.

IT IS FURTHER ORDERED that an **informal public hearing** pursuant to Section 59A-4-18 NMSA 1978 be held on Wednesday, July 15, 2009 at 9:30 a.m. in the Public Regulation Commission, Fourth Floor Hearing Room, P.E.R.A. Building, corner of Paseo de Peralta and Old Santa Fe Trail, Santa Fe, New Mexico for the purpose of receiving oral public comments including data, views, or arguments on the proposed rulemaking. All interested persons wishing to present oral comments may do so at the hearing. Interested persons should contact the Insurance Division ahead of time to confirm the hearing date, time and place since hearings are occasionally rescheduled.

IT IS FURTHER ORDERED that all interested parties may file **written comments** on the proposed rulemaking on or before July 10, 2009. An original and (2) two copies of written comments and suggested changes concerning the proposed rule, "2010 Medicare Supplement Plan Standards," must be mailed or delivered to: NM Public Regulation Commission - Docketing Division, ATTN: Mariano Romero, RE: Proposed Rulemaking "2010 Medicare Supplement Plan Standards" in Docket No. 09-00216-IN, Public Regulation Commission's Docketing Office, Room 406, PO Box 1269, Santa Fe, NM 87504-1269. Telephone: (505) 827-4368. If possible, please also e-mail a copy of written comments as an attachment in

Microsoft Word format to Melinda.Silver@state.nm.us, or call her at 505-827-6904 to notify her that comments were submitted to the Docketing Office. Comments will be available for public inspection during regular business hours in the Docketing Office, Room 406, P.E.R.A. Building, 1120 Paseo de Peralta, corner of Paseo de Peralta and Old Santa Fe Trail, Santa Fe, NM.

IT IS FURTHER ORDERED that the Superintendent may require the submission of additional information, make further inquiries, and modify the dates and procedures if necessary to provide for a fuller record and a more efficient proceeding.

IT IS FURTHER ORDERED that Insurance Division Staff shall cause a copy of this Notice to be published once in the New Mexico Register and once in the Albuquerque Journal.

PLEASE BE ADVISED THAT the New Mexico Lobbyist Regulation Act, Section 2-11-1 et seq., NMSA 1978 regulates lobbying activities before state agencies, officers, boards and commissions in rulemaking and other policy-making proceedings. A person is a lobbyist and must register with the Secretary of State if the person is paid or employed to do lobbying or the person represents an interest group and attempts to influence a state agency, officer, board or commission while it is engaged in any formal process to adopt a rule, regulation, standard or policy of general application. An individual who appears for himself or herself is not a lobbyist and does not need to register. The law provides penalties for violations of its provisions. For more information and registration forms, contact the Secretary of State's Office, State Capitol Building, Room 420, Santa Fe, NM 87503, (505) 827-3600.

PLEASE BE ADVISED THAT individuals with a disability, who are in need of a reader, amplifier, qualified sign language interpreter or any other form of auxiliary aid or service to attend or participate in the hearing, may contact the Docketing Office at (505) 827-4368. Public documents associated with the hearing can be provided in various accessible forms for disabled individuals. Requests for summaries or other types of accessible forms should be addressed to Mr. Romero.

DONE, this 11 day of June, 2009.

NEW MEXICO PUBLIC REGULATION COMMISSION
INSURANCE DIVISION

RONNY LUJAN, Deputy Superintendent of Insurance

NEW MEXICO DEPARTMENT OF PUBLIC SAFETY

NEW MEXICO DEPARTMENT
OF PUBLIC SAFETY
NOTICE OF PUBLIC HEARING

The New Mexico Department of Public Safety (NMDPS) will be holding a Public Hearing for the sake of receiving comments on two new Rules regarding the application procedures governing the 2008/2009 Edward Byrne Memorial Justice Assistant Grant Program (JAG) and the 2009 Edwards Byrne Memorial Justice Assistance Grant (JAG) under the Recovery Act Program. The hearing will be held at 1:30 P.M. on Tuesday, July 28, 2009 at the New Mexico Law Enforcement Academy Auditorium, 4491 Cerrillos Road, Santa Fe, New Mexico 87507. The new Rules will include, but not limited to, changes, additions, deletions, and clarifications of the application process.

Copies of the proposed Rules shall be made available to the public ten days prior to the Public Hearing and may be obtained by calling 505-827-9112. The new Rules are also posted on the Department of Public Safety's website and may be accessed, free of charge, from the following website: http://www.dps.nm.org/

Comments on the new Rules are invited. Oral comments may be made at the hearing, or written comments may be submitted by mail to the Grants Management Bureau, New Mexico Department of Public Safety, Post Office Box 1628, Santa Fe, New Mexico 87504-1628, no later than Aug 2, 2009. Any individual with a disability, who is in need of a reader, amplifier, or other form of auxiliary aid or service in order to attend or participate in the hearing, should contact Evelyn Romero, 505-827-3347 at least ten (10) day prior to the hearing.

NEW MEXICO RACING COMMISSION

NOTICE OF REGULAR MEETING AND RULE HEARING

NOTICE IS HEREBY GIVEN that the New Mexico Racing Commission will hold a Regular Meeting and Rule Hearing on August 19, 2009. The hearing will be held during the Commission's regular business meeting, beginning at 8:30 a.m. with executive session. Public session will begin at 9:30 a.m. The meeting will be held at the State Personnel Office, Leo Griego Auditorium, 2600 Cerrillos Road, Santa Fe, New Mexico.

The purpose of the Rule Hearing is to consider adoption of the proposed amendments and additions to the following Rules Governing Horse Racing in New Mexico No. 15.2.1 NMAC, 15.2.2 NMAC, 15.2.3 NMAC, 15.2.4 NMAC, 15.2.5 NMAC, 15.2.6 NMAC, 15.2.7 NMAC AND 16.47.1 NMAC. The comments submitted and discussion heard during the Rule Hearing will be considered and discussed by the Commission during the open meeting following the Rule Hearing. The Commission will vote on the proposed rules during the meeting.

Copies of the proposed rules may be obtained from Julian Luna, Agency Director, New Mexico Racing Commission, 4900 Alameda Blvd NE, Suite A, Albuquerque, New Mexico 87113, (505) 222-0700. Interested persons may submit their views on the proposed rules to the commission at the above address and/or may appear at the scheduled meeting and make a brief verbal presentation of their view.

Anyone who requires special accommodations is requested to notify the commission of such needs at least five days prior to the meeting.

_____
Julian Luna
Agency Director

Dated: June 16, 2009

NEW MEXICO REAL ESTATE APPRAISERS BOARD

Legal Notice on Rule Hearing

Pursuant to Section 10-15-1 of the Open Meetings Act, Section 61-30-7 of the Real Estate Appraisers Act, and Section 23 of the Appraisal Management Company Registration Act notice is hereby given that the New Mexico Real Estate Appraisers Board will hold a rule hearing on **Friday, August 14, 2009** at the Regulation and Licensing Department in the main conference room located at 5200 Oakland Ave. NE in Albuquerque, New Mexico. The hearing

will begin at **8:30 am**.

The purpose of the hearing is to receive public comment regarding proposed amendments to 16.62 NMAC, Part 1: General Provisions, Part 10: Temporary Practice and proposed rules to implement the Appraisal Management Company Registration Act. Rules to implement the Appraisal Management Company Registration Act will be adopted under Title 16 Chapter 65 NMAC, Part 1: General Provisions, Part 2: Requirements for Registration, Part 3: Application for Registration, Expiration and Renewal, Part 4: Discipline, Part 5: Fees

Interested persons may testify at the hearing or submit written comments no later than **September 10, 2009**. Written comments will be given the same consideration as oral testimony given at the hearing. Written comments should be addressed to: Real Estate Appraisers Board, 2550 Cerrillos Rd., Santa Fe, NM 87501, or e-mailed to www.real.estate.appraisers.board@state.nm.us.

Interested parties can obtain copies of the proposed rules by visiting the Board's website www.rld.state.nm.us/RealEstateAppraiser.com, writing to or visiting the Board office at 2550 Cerrillos Road in Santa Fe, New Mexico 87504 or by calling (505) 476-4860.

If you are an individual with a disability who wishes to attend the hearings, but you need a reader, assistive listening device, or any other form of auxiliary aid or service to participate, please call the Board office at (505) 476-4860 at least two weeks prior to the hearing or as soon as possible.

End of Notices and Proposed Rules Section

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Adopted Rules

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.262.400 NMAC, sections 7, 11, 13, 14, 17 and 19, which will be effective July 1, 2009.

8.262.400.7 DEFINITIONS:

A. **Action:** The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, modification, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or a failure to provide a service in a timely manner. An untimely service authorization constitutes a denial and is thus considered an action.

B. **Authorized representative:** An individual or entity for whom or for which the applicant has signed a release of confidentiality and to whom notices will be sent.

C. **Benefits:** SCI-covered services provided by the SCI-participating MCO and for which payment is included in the capitation rate, as defined in 8.262.600 NMAC.

D. **Capitation:** A per-member, monthly payment to an MCO that covers contracted services and is paid in advance of service delivery. It is a set amount of money received or paid out, based on membership rather than on services delivered. It is usually expressed in units of "per member per month" (PMPM).

E. **Catastrophic coverage:** Insurance coverage for specific catastrophic events, such as death, fire, flood, and some medical conditions.

F. **Category:** A designation of the automated eligibility system. The assigned category is applicable for a period of 12 consecutive months regardless of changes in income or family status, subject to change by request from the recipient.

G. **Cost-sharing:** Premiums and copayments owed by the member based on income group category.

H. **Cost-sharing maximum:** The cost sharing maximum is determined during the initial eligibility determination and recertification process. The cost sharing maximum amount established at the point of eligibility determination for the benefit year represents an amount equal to [~~5%~~] five percent of the program participant's countable income.

I. **Coverage:** Coverage month is a month where all eligibility and enrollment requirements including premium payment, if applicable, are met.

J. **Eligibility:** The process of establishing that SCI residency, citizenship or alien status, health insurance coverage, income, living arrangement, and age requirements are met, as defined in this part and 8.262.500 NMAC.

K. **Employer:** An employer with fifty or fewer eligible employees on a full or part-time basis.

L. **Employer group:** A group of employees employed by an eligible employer who receives SCI benefits through the employer.

M. **Employee:** A person employed by an employer who participates in the SCI health benefit plan.

N. **Employer enrollment period:** Employer's standard practice for new and annual health insurance enrollment.

O. **Enrollment:** The process of enrolling eligible members in an MCO for purposes of management and coordination of health care delivery. The process of enrolling members either by the employer or individually in an available SCI-participating MCO for purposes of health care coverage. Enrollment encompasses selection of an MCO, notification of the selection to the MCO, and timely payment of premiums, as required, as designed by the MCO.

P. **Eligibility letter:** A notice of SCI eligibility and the potential for SCI coverage contingent upon enrollment with a SCI participating MCO. The letter will include start and end dates of eligibility, the requirement to enroll before coverage will begin, and the need to enroll [~~30~~] 90 days subsequent to the month of issuance of the enrollment letter. The letter will also notify the member of the federal poverty level subcategory and of the responsibility to track out-of-pocket expenditures for SCI cost sharing.

Q. **Fifth degree of relationship:** The following relatives are within the fifth degree of relationship to a dependent child:

(1) father (biological or adopted);

(2) mother (biological or adopted);

(3) grandfather, great grandfather, great-great-grandfather, great-great-great-grandfather;

(4) grandmother, great grandmother, great-great-grandmother, great-great-great-grandmother;

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

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

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

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

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

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

(11) first cousin and spouse of first cousin;

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

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

(14) nephew/niece and spouses.

(15) ***Note:*** A second cousin is a child of a first cousin once removed or child of a child of a great aunt or uncle and is not within the fifth degree of relationship.

R. **Fiscal agent (medicaid fiscal agent):** An entity contracted by the state medicaid program to sort and process eligibility information as well as pay fee-for-service and capitation claims.

S. **Grievance (member):** Oral or written statement by a member expressing dissatisfaction with any aspect of the MCO or its operations that is not an MCO action.

T. **Group of one:** Individuals who enroll without an employer group but report self-employment.

U. **Health insurance:** Insurance against loss by sickness or bodily injury. The generic term for any forms of insurance that provides lump sum or periodic payments in the event of bodily injury, sickness, or disease, and medical expense. This includes but is not exclusive of: medicare part A or medicare part B, medicaid, CHAMPUS, and other forms of government health coverage.

V. **Hearing or administrative hearing:** An evidentiary hearing that is conducted so that evidence may be presented.

W. **Income groupings- 0-100[~~%~~] percent, 101-150[~~%~~] percent, and 151-200[~~%~~] percent of federal poverty levels:** These income groupings define the premium, copayment, and cost-sharing maximums for SCI cost-sharing purposes.

X. **Individual:** A person who enrolls in SCI who is not a member of an eligible employer group and pays the premium amount designated for both the employee share, if applicable based on household income, and the employer share, or has that amount paid on his/her behalf by another entity.

Y. **Individual health plan**: Health insurance coverage purchased by an individual from an insurer offering individual healthcare benefit policies.

Z. **Managed care organization (MCO):** An organization licensed or authorized through an agreement among state entities to manage and coordinate and receive payment at actuarially sound payment rates for the delivery of specified services to enrolled members from a certain geographic area.

AA. **Member:** An eligible member enrolled in an MCO.

BB. **Member month:** A calendar month in which a member is enrolled in an MCO.

CC. **Notice:** A written statement that includes what action is being taken, the reasons for the intended action, the specific regulation that requires the action, and an explanation of the circumstances under which the service may be continued if a hearing is requested.

DD. **Parental or custodial relative status:** The state of having a dependent child under the age of 18 who is the son, daughter, or relative within the fifth degree of relationship living in the household and under the care and control of the individual.

EE. **Premium- employer:** A specific monthly payment payable to the MCO by employers who enroll their employees in SCI at a rate set by the department. This amount may be paid by an individual member not in an employer group in order to participate in SCI. Subject to available funding, the state may allocate funds to assist certain eligible individuals with payment of the employer premium contribution and will notify eligible individuals of such assistance. Premiums cannot be refunded.

FF. **Premium- employee:** A specific monthly payment payable to the MCO calculated by the department based on a subcategory of eligibility representing an income grouping. 062-0-100[~~%~~] percent FPL, 062-101-150[~~%~~] percent FPL, 062-151-200[~~%~~] percent FPL. Premiums and copayments cannot be refunded.

GG. **Qualifying event:** Termination of employment for any reason; loss of eligibility for health insurance benefits due to reduction in work hours; loss of health insurance coverage due to death, divorce or legal separation from spouse, loss of dependent status; moving to or from another state.

HH. **SCI (state coverage insurance):** The New Mexico health care program implemented under the authority of the health insurance flexibility and accountability (HIFA) waiver granted to the state by the centers for medicare and medicaid services (CMS).

II. **Shoebox method:** The method under which an SCI member is responsible for tracking, and submission of a request for verification of total expenditures for himself, based on SCI employee premiums and copayments for purposes of establishing that the cost-sharing maximum amount has been met.

JJ. **Voluntary drop:** The act of voluntarily terminating or discontinuing health insurance coverage.

[8.262.400.7 NMAC - N, 7-1-05; A, 3-1-06; A, 4-16-07; A/E, 8-1-07; A, 6-1-08; A, 7-1-09]

8.262.400.11 ELIGIBILITY: To be eligible for SCI, an individual must meet all eligibility criteria regarding age, citizenship or alien status, noninsured status (including ineligible for medicaid or medicare), voluntary drop of insurance, household income, and living arrangement (i.e., living in a public institution). An eligibility determination will be made by the 45th day after the date of application. If it is determined that an individual does not meet all SCI eligibility criteria, a notice of denial with the reason for denial and rights to appeal will be issued. If it is determined that an individual meets all eligibility criteria, the individual will be awarded an "eligibility letter," which will notify the individual of their right to enroll, and of the fact that coverage will not begin unless and until the individual is enrolled and has paid the determined premium amount, if required, to a SCI-contracted MCO. No partial payments of premiums will be allowed.

[8.262.400.11 NMAC - N, 7-1-05; A, 4-16-07; A/E, 8-1-07; A, 7-1-09]

8.262.400.13 ENROLLMENT: To be considered enrolled in a given month, an individual must have selected an MCO and become enrolled, and the MCO must consider his premium(s) to be paid. Upon each positive eligibility determination, an enrollment letter will be issued, advising the individual that SCI coverage will begin upon completed enrollment with a SCI-contracted MCO. Individuals have 90 days from the date of approval notice to enroll with the selected MCO. Failure to enroll with the MCO within the 90-day required timeframe may result in closure of program eligibility. Each month, the MCO will provide a roster that includes each enrolled individual. Each SCI-contracted MCO will notify the individual or the employer of the owed premium amount, if required, for the ongoing month. If the premiums are not paid on time, the MCO will send advance notice of closure to the member, prior to termination of coverage due to nonpayment. The MCO will subsequently notify the individual of the termination and the requirements for reenrollment.

[8.262.400.13 NMAC - N, 7-1-05; A/E, 8-1-07; A, 7-1-09]

8.262.400.14 REENROLLMENT:

A. Individual members who have been terminated due to failure to enroll within the required timeframe or to make premium payment or for late payment will be unable to reenroll for a period of six months subsequent to the first month of termination due to failure to enroll or make premium payments *and* until payment of late or defaulted premiums if so required by the MCO. Employer members who have been terminated due to failure to make premium payment or for late payment will be unable to reenroll for a period of [~~twelve~~] 12 months subsequent to the first month of termination due to failure to make premium payments *and* until payment of late or defaulted premiums if so required by the MCO. As a condition of reenrollment an MCO may require an employer to repay overdue premiums as well as require two months premium payments in advance after termination due to nonpayment or late payment.

B. SCI members whose eligibility was closed due to short-term receipt (six months or less) of full coverage medicaid or medicare may have SCI eligibility re-determined and may be able to reenroll with the SCI MCO. Such individuals must meet the following criteria in order to reenroll in SCI:

(1) must have received full-coverage medicaid or medicare eligibility for six months or less and had such eligibility closed sometime during the six months prior to re-application for SCI;

(2) must be determined ineligible for medicaid or medicare; and

(3) must have had SCI eligibility and completed the enrollment process with an SCI MCO for some period of time during the six months prior to re-application.

C. Upon meeting the above criteria, individuals must submit an updated SCI application, including income information from the most recent past 30 days, to the SCI income support division unit. If determined still eligible for SCI, such individuals may re-enroll with the MCO.

[8.262.400.14 NMAC - N, 7-1-05; A, 7-1-09]

8.262.400.17 SPECIAL RECIPIENT REQUIREMENTS:

A. **Age:** To be eligible for SCI, an individual must be age 19 through 64.

B. **Continuing eligibility on the factor of age:** When an individual has been determined eligible on the condition of age, he remains eligible on the condition until the applicable upper age limit is reached. An individual who exceeds the

age limit during a given month is eligible for that month, unless the birthday is the first day of the month.

C. **Uninsured:** For purposes of SCI eligibility, an individual cannot have health insurance coverage, excluding catastrophic or supplemental health insurance policies. An individual with access to health care at Indian health services, veteran's administration, or through worker's compensation, is not considered to be insured for purposes of this program by having such access.

D. **Enrolled:** An individual who has been determined eligible for SCI must notify an SCI-contracted MCO and must have made and continue to make premium payment as a condition of SCI coverage.

E. **Premium payment**: SCI requires payment of premiums by the employer at a rate established by the department, and by the employee per month as calculated by income level: 062A, 062B and 062C. Some individuals may be required to pay both the employers and employee's share based on income level. Nothing in this section prevents another entity from contributing the employer or employee premium share on behalf of an individual member. Nothing in this section prevents the employer or a third party from paying the employee portion of the premium on behalf of the employee. The due date of premium payments will be determined by the MCO. If an individual's category of SCI eligibility changes at annual recertification for the program, resulting in a different premium payment due, the new premium amount is effective beginning with the first month of the new recertification approval period. Individuals who fail to pay the premium within the timeframe established by the MCO may be disenrolled.

F. **Voluntary drop of health insurance:** An individual who has voluntarily dropped health insurance will be ineligible for SCI for six months, starting with the first month the health insurance was dropped (i.e., the first month of no coverage). An employer who has voluntarily dropped health insurance will be ineligible to enroll employees in SCI for twelve months. The following circumstances are not considered a voluntary drop:

(1) an individual (or spouse) fails to take advantage of an initial offer of health insurance by an employer (unless the insurance is SCI coverage), or fails or refuses to take advantage of a COBRA continuation policy;

(2) loss of access to employer-sponsored insurance due to loss of employment, divorce, death of a spouse, or geographic move, loss of coverage as a dependent child, or loss of medicaid eligibility; or

(3) an employee enrolled in an individual health plan whose employer is offering SCI employer-sponsored insurance (as an initial offering or at open enrollment) will be able to participate in SCI under group coverage and will not be considered to have voluntarily dropped health insurance in order to participate in the SCI employer group plan.

G. **Cost-sharing maximums:** An SCI-covered individual is responsible for tracking and reporting of the cost-sharing amount paid in a benefit year, and for reporting to the managed care organization (MCO) when the cost-sharing maximum amounts are met (also known as "shoebox methodology"). The first month of coverage without cost-sharing will be the month after the month of verification that the maximum expenditure limit has been met, unless the determination is made after the 24th of the month. Where the determination is made after the 24th of the month, the first month of coverage without cost-sharing will be the second month after verification. The period of coverage without cost-sharing will end on the last day of that benefit year. No partial payments of premiums or of copayments will be allowed. No premiums or copayments will be refunded.

[8.262.400.17 NMAC - N, 7-1-05; A, 4-16-07; A/E, 8-1-07; A, 7-1-09]

8.262.400.19 NON-CONCURRENT RECEIPT OF ASSISTANCE: An SCI applicant/recipient cannot be simultaneously approved for any of the other New Mexico medicaid categories, any kind of partial or full medicare coverage, or for any medicaid program in another state. If the SCI member is given retroactive eligibility for medicaid or medicare, SCI premiums and copayments paid by the member will not be refunded for the months in which the client was later found to be retroactively eligible [~~for medicaid~~].

[8.262.400.19 NMAC - N, 7-1-05; A, 4-16-07; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.262.500 NMAC, Section 9, which will be effective July 1, 2009.

8.262.500.9 ESTABLISHING NEED - GENERAL REQUIREMENTS: Methodology for establishing financial eligibility for state coverage insurance (SCI) uses New Mexico works cash assistance definitions of income, rules for income availability, and exempt income with the exception of Subsection C of 8.102.520.11 NMAC and Subsection B of 8.102.520.12 NMAC, which refer to the methodology for determining self-employment income.

A. **Income test:** In order to be eligible for SCI, countable income (after applicable exemptions and disregards) must meet the SCI household income limit for the appropriate family size. The SCI income standards are based on 200[~~%~~] percent of federal poverty levels (FPLs). SCI uses New Mexico works income definitions and methodologies with the exception of Subsection C of 8.102.520.11 NMAC and Subsection B of 8.102.520.12 NMAC. (Also see 8.102.520.8 NMAC through 8.102.520.15 NMAC). SCI eligibility and cost-sharing levels will be determined based on one income test using countable income (after applicable exemptions and disregards).

B. **Determining income for self-employed individuals:** Reports to state and federal tax authorities are the usual indicators of self-employment income (refer to Subparagraph (b) of Paragraph (2) of Subsection B of 8.100.130.14 NMAC for other acceptable documents that may be submitted to determine self-employment income). To determine self-employment income, apply the following methodology:

(1) use the amount listed on line 31 (net profit or loss) of schedule C or line 36 (net profit or loss) of Schedule F, or the net profit/loss line of other schedules deemed applicable to self-employment income, of the most recent or previous year's 1040 income tax return to determine annual self-employment income;

(2) divide the amount by 12 or by the applicable number of months in business to determine monthly self-employment income.

C. **Payment standard increments:** Payment standard increments for nonsubsidized housing living arrangements and clothing allowance do not affect the SCI eligibility process, i.e., the eligibility limits for income are not increased by the amount of the nonsubsidized housing or clothing allowance payment increments.

D. **Excess hours work deduction:** This deduction is not applicable to SCI.

E. **SCI category designation:** SCI eligibles will be assigned one category of eligibility (062). The income grouping (subcategory) will control the employee premium and copayment amounts.

[8.262.500.9 NMAC - N, 7-1-05; A, 3-1-06; A, 6-1-08; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.262.600 NMAC, Section 9 and 11, which will be effective July 1, 2009.

8.262.600.9 BENEFIT DESCRIPTION: The benefit package is described in 8.306.7. NMAC, *Benefit Package*, SCI benefits are administered by contracted managed care organizations. There is no fee-for-service coverage under the SCI program.

A. The level of cost-sharing (i.e., the premium and co-payment amounts as well as the cost-sharing maximum amounts) required in the SCI program is contingent upon the income grouping associated with the applicant's countable household income at the point of the application disposition. See also 8.262.500.9 NMAC.

B. The cost-sharing maximum is an amount calculated for the benefit year that represents an amount equal to [~~5%~~] five percent of the [~~enrollee~~] enrollee's countable household income at the time of the application disposition. It is the responsibility of each SCI-covered individual to track and total the amounts paid for the SCI employee portion of the premiums and SCI co-payments on SCI-covered services in a benefit year. Once the cost-sharing maximum amount has been paid by an SCI-covered individual, the individual must notify the MCO and provide verification of the paid amounts. Once the paid amounts have been verified as paid, the individual will not owe further employee premium or co-payment amounts for the remainder of that benefit year. The first month that cost sharing is not required by the SCI-covered individual is the month following the month in which it has been verified by the MCO that the cost-sharing maximum amount has been met. If the determination is made after the 24th of the month, the change is made effective the second month after the verification. No retroactive eligibility for the "met cost-sharing maximum" amount is allowed. The employer portion of the premium is not counted toward the cost-sharing maximum and must be paid by (or on behalf of) the individual enrollee each month regardless of income category or cost-sharing maximum status. Premium payments must be paid in full each month, even if the cost-sharing maximum has been reached and there is an overpayment. No partial payments of premiums or copayments will be allowed. No premiums or copayments will be refunded.

C. Employer share payable by individual: An individual member (one who is enrolled outside of an employer group) may be responsible for payment of the premium share for the employee as determined by federal poverty level and the employer premium. The employer portion of the premiums will not be counted toward the cost-sharing maximum.

[8.262.600.9 NMAC - N, 7-1-05; A, 3-1-06; A, 4-16-07; A/E, 8-1-07; A, 7-1-09]

8.262.600.11 CONTINUOUS ELIGIBILITY: Eligibility will continue for the [~~twelve~~] 12-month certification period, regardless of changes in household income, as long as the individual retains New Mexico residency and continues to be ineligible for other medicaid or medicare coverage and is less than 65 years of age. Twelve-month continuous eligibility shall not be affected by the disposition of any other benefit(s) such as TANF, food stamps, etc. HSD will notify members, whether employees enrolled through an employer group or individuals, [~~forty-five (45)~~] 45 days prior to the end of the recertification period. Members are responsible for recertifying eligibility within the [~~forty-five (45)~~] 45 day period prior to expiration of the eligibility certification period and notifying the MCO or the employer of their interest in recertification. Failure of the member to follow up with his/her recertification responsibilities within the required timeframe, including the submission of updated income documents, may result in termination from the SCI program.

[8.262.600.11 NMAC - N, 7-1-05; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.1 NMAC, Sections 7 and 8 which will be effective July 1, 2009.

8.305.1.7 DEFINITIONS: The state of New Mexico is committed to improving the health status of New Mexico residents whose health care services are funded by the Title XIX (medicaid) program. As a means of improving health status, a capitated managed care plan has been implemented. This section contains the glossary for the New Mexico medicaid managed care policy. The following definitions apply to terms used in this chapter.

A. Definitions beginning with letter "A":

(1) **Abuse:** Provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary cost to medicaid [~~, or the interagency behavioral health purchasing collaborative (the collaborative),~~] in reimbursement for services that are not medically necessary, or in services that fail to meet professionally recognized standards for health care. Abuse also includes client or member practices that result in unnecessary costs to medicaid [~~or the collaborative~~].

(2) **Action:** The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure to provide services in a timely manner. An untimely service authorization constitutes a denial and is thus considered an action.

(3) **Appeal, member:** A request from a member or provider, on the member's behalf with the member's written permission, for review by the managed care organization (MCO) or the single statewide entity (SE) for behavioral health of an MCO or SE action as defined above in Paragraph (2) of Subsection A of 8.305.1.7 NMAC.

(4) **Appeal, provider:** A request by a provider for a review by the MCO or SE of an MCO or SE action related to the denial of payment or an administrative denial.

(5) **Approvals:** Approvals are either initial or concurrent review decisions, which yield utilization management authorizations based on the client meeting the clinical criteria for the requested medicaid service(s) or level of care.

(6) **Assignment algorithm:** Predetermined method for assigning mandatory enrollees who do not select an MCO.

B. Definitions beginning with letter "B":

(1) **Behavioral health:** Refers to mental health and substance abuse.

(2) **Behavioral health planning council (BHPC):** Refers to the council created by HB 271 to meet federal advisory council requirements and to provide consistent, coordinated input to behavioral health service delivery in New Mexico. The SE will be expected to interact with the BHPC as an advisory council.

(3) **Behavioral health purchasing collaborative:** Refers to the interagency behavioral health purchasing collaborative pursuant to the passage of HB 271, effective May 19, 2004. The collaborative is made up of 17 publicly funded statutory member agencies, including eight agencies that provide and fund direct services, including the human services department.

(4) **Benefit package:** Medicaid covered services that must be furnished by the MCO/SE and for which payment is included in the capitation rate.

C. Definitions beginning with letter "C":

(1) **Capitation:** A per-member, monthly payment to an MCO/SE that covers contracted services and is paid in advance of service delivery. A set amount of money received or paid out, based on membership rather than on services delivered. It is usually expressed as "per member per month" (PM/PM).

(2) **Care coordination for behavioral health:** An office-based administrative function to assist members with multiple, complex and special cognitive, behavioral or physical health care needs on an as needed basis. It is member-centered and consumer-directed, family-focused when appropriate, culturally competent and strengths-based. Care coordination ensures that medical and behavioral health needs are identified and services are provided and coordinated with the member and family, if appropriate. Care coordination operates independently within the SE and has separately defined functions with a dedicated care coordination staff, but is structurally linked to other SE systems, such as quality assurance, member services and grievances. Clinical decisions shall be based on the medically necessary covered services and not fiscal or administrative considerations. The care coordinator coordinates services within the behavioral health delivery system, as well as with other service providing systems. The care coordinator may interface and collaborate with the consumer's case manager, if applicable, for those who receive case management services. If both physical and behavioral health conditions exist, the primary care coordination responsibility lies with the condition that is most acute.

(3) **Care coordination for physical health:** An office-based administrative function to assist members with multiple, complex and special cognitive, behavioral or physical health care needs on an as needed basis. It is member-centered and consumer-directed, family-focused when appropriate, culturally competent and strengths-based. Care coordination ensures that medical and behavioral health needs are identified and services are provided and coordinated with the member and family if appropriate. Care coordination operates independently within the MCO and has separately defined functions with a dedicated care coordination staff, but is structurally linked to other MCO systems, such as quality assurance, member services and grievances. Clinical decisions shall be based on the medically necessary covered services and not fiscal or administrative considerations. The care coordinator coordinates services within the physical health delivery system, as well as with other service providing systems. The care coordinator may interface and collaborate with the member's case manager, if applicable, for those who receive case management services. If both physical and behavioral health conditions exist, the primary care coordination responsibility lies with the condition that is most acute.

(4) **Care coordination plan/individual plan of care (SE only):** The care coordination plan is based on a comprehensive assessment of the goals, capacities and the behavioral health service needs of the member and with consideration of the needs and goals of the family, if appropriate.

(5) **Case:** A household that medicaid treats as a unit for purposes of eligibility determination; for example, a parent and child; a legal guardian and child; or a set of siblings.

(6) **Case management for physical health:** The targeted case management programs, that are part of the medicaid benefit package. The targeted case management programs will continue to be important service components. In these programs, case managers typically function independently and assess a member's/family's needs and strengths; develop a service/treatment plan, coordinate, advocate for and link members to all needed services related to the targeted case management program.

(7) **Children with special health care needs (CSHCN):** Individuals under 21 years of age, who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition, and who also require health and related services of a type or amount beyond that required by children generally.

(8) **Clean claim:** A manually or electronically submitted claim from a participating provider that contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside the health plan's system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. A clean claim is not materially deficient or improper, such as lacking substantiating documentation currently required by the health plan, or has no particular or unusual circumstances requiring special treatment that prevents payment from being made by the health plan within 30 days of the date of receipt if submitted electronically or 45 days if submitted manually.

(9) **Client:** An individual who has applied for and been determined eligible for Title XIX (medicaid). A "client" may also be referred to as a "member", "customer", or "consumer".

(10) **CMS:** Centers for medicare and medicaid services.

(11) **Community-based care:** A system of care, which seeks to provide services to the greatest extent possible, in or near the member's home community.

(12) **Comprehensive community support services:** These services are goal-directed mental health rehabilitation services and supports for children, adolescents, and adults necessary to assist individuals in achieving recovery and resiliency goals. These services assist in the development and coordination of a member's service plan and include therapeutic interventions which address barriers that impede the development of skills necessary for independent functioning in the community.

(13) **Continuous quality improvement (CQI):** CQI is a process for improving quality that assumes opportunities for improvement are unlimited; is customer-oriented, data driven, and results in implementation of improvements; and requires continual measurement of implemented improvements and modification of improvements, as indicated.

(14) [~~**Coordinated**~~] **Coordination of long-term services [~~(CLTS)~~] (CoLTS):** A coordinated program of physical health and community-based supports and services implemented under the authority of concurrent section 1915(b) and section 1915(c) home and community-based waivers. The [~~CLTS~~] CoLTS program includes individuals eligible for both medicare and medicaid, and persons eligible for medicaid long-term care services based on assessed need for nursing facility level of care. The [~~CLTS~~] CoLTS program does not include individuals who meet eligibility criteria set forth in New Mexico's developmental disabilities, AIDS and medically fragile waiver programs.

(15) **Cultural competence:** A set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals, that enables them to work effectively in cross-cultural situations. Cultural competency involves the integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques and marketing programs that match an individual's culture and increase the quality and appropriateness of health care and outcomes.

D. Definitions beginning with letter "D":

(1) **Delegation:** A formal process by which an MCO/SE gives another entity the authority to perform certain functions on its behalf. The MCO/SE retains full accountability for the delegated functions.

(2) **Denial-administrative/technical:** A denial of authorization requests due to the requested procedure, service or item not being covered by medicaid, not

being on the MCO/SE formulary or due to provider noncompliance with administrative policies and procedures established by either the MCO/SE or the medical assistance division.

(3) **Denial-clinical:** A non-authorization decision at the time of an initial request for a medicaid service or a formulary exception request based on the member not meeting medical necessity for the requested service. The utilization management (UM) staff may recommend an alternative service, based on the client's need for a lower level of service. If the requesting provider accepts this alternative service, it is considered a new request for the alternative service and a clinical denial of the original service request.

(4) **Disease management plan:** A comprehensive plan following nationally recognized components for chronic disease interventions including population identification/stratification process, collaborative practice models, patient self-management education process, evidence-based practice guidelines, process and outcomes measurements, and internal quality improvement processes.

(5) **Disenrollment, MCO initiated:** When requested by an MCO for substantial reason, removal of a medicaid member from membership in the requesting MCO, as determined by HSD, on a case-by-case basis.

(6) **Disenrollment, member initiated (switch):** When requested by a member for substantial reason, transfer of a medicaid member as determined by HSD on a case-by-case basis, from one MCO to a different MCO during a member lock-in period.

(7) **Durable medical equipment (DME):** Equipment that can withstand repeated use, is primarily used to serve a medical purpose, is not useful to individuals in the absence of an illness or injury and is appropriate for use at home.

E. Definitions beginning with letter "E":

(1) **Emergency:** An emergency condition is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part.

(2) **Encounter:** The record of a physical or behavioral health service rendered by a provider to an MCO/SE member, client, customer, or consumer.

(3) **Enrollee:** A medicaid recipient who is currently enrolled in a managed care organization in a given managed care program.

(4) **Enrollee rights**: Rights which each managed care enrollee is guaranteed.

(5) **Enrollment:** The process of enrolling eligible clients in an MCO/SE for purposes of management and coordination of health care delivery.

(6) **EPSDT:** Early and periodic screening, diagnostic and treatment.

(7) **Exempt:** The enrollment status of a client who is not mandated to enroll in managed care.

(8) **Exemption:** Removal of a medicaid member from mandatory enrollment in managed care and placement in the medicaid fee-for-service program. Such action is only for substantial reason, as determined by HSD on a case-by-case basis.

(9) **Expedited appeal:** A federally mandated provision for an expedited resolution within three working days of the requested appeal, which includes an expedited review by the MCO/SE of an MCO/SE action.

(10) **External quality review organization (EQRO):** An independent organization with clinical and health services expertise capable of reviewing the evidence of compliance of health care delivery and internal quality assurance/improvement requirements.

F. Definitions beginning with letter "F":

(1) **Family-centered care:** When a child is the patient, the system of care reflects the importance of the family or legal guardian in the way services are planned and delivered. Family-centered care facilitates collaboration between family members and medical professionals, builds on individual and family strengths and respects diversity of families.

(2) **Family planning services:** Services provided to members of childbearing age to temporarily or permanently prevent or delay pregnancy (see MAD-762, *Reproductive Health Services*).

(3) **Fee-for-service (FFS):** The traditional medicaid payment method whereby payment is made by HSD to a provider after services are rendered and billed.

(4) **Fraud:** An intentional deception or misrepresentation made by an entity or person, including but not limited to, an MCO/SE, subcontractor, provider or client with the knowledge that the deception could result in some unauthorized benefit to himself or to some other previously described entity or person. It includes any act that constitutes fraud under applicable federal or state law.

(5) **Full risk contracts:** Contracts that place the MCO/SE at risk for furnishing or arranging for comprehensive services.

G. Definitions beginning with letter "G":

(1) **Gag order:** Subcontract provisions or MCO/SE practices, either written, oral or implied, that effectively prevent a provider from furnishing accurate or complete information to members about options for diagnosis or treatment of physical, mental or behavioral illness, injury, or condition; or prevent a provider from talking to the member or HSD about the MCO/SE or its business practices.

(2) **Grievance (member):** Oral or written statement by a member expressing dissatisfaction with any aspect of the MCO/SE or its operations that is not an MCO/SE action.

(3) **Grievance (provider):** Oral or written statement by a provider to the MCO/SE expressing dissatisfaction with any aspect of the MCO/SE or its operations that is not an MCO/SE action.

H. Definitions beginning with letter "H":

(1) **HCFA:** Health care financing administration. Effective 2001, the name was changed to centers for medicare and medicaid services (CMS).

(2) **Health plan:** A health maintenance organization (HMO), managed care organization (MCO), prepaid inpatient health plan (PIHP), or third party payer or their agents.

(3) **HIPAA:** Health Insurance Portability and Accountability Act of 1996.

(4) **Hospitalist:** A physician employed by a hospital to manage the care of a member admitted to the hospital for inpatient care.

(5) **Human services department (HSD):** The sole executive department in New Mexico responsible for the administration of Title XIX (medicaid). "HSD" may also indicate the department's designee, as applicable.

I. Definitions beginning with letter "I":

(1) **IBNR (claims incurred but not reported):** Claims for services authorized or rendered for which the MCO/SE has incurred financial liability, but the claim has not been received by the MCO/SE. This estimating method relies on data from prior authorization and referral systems, other data analysis systems and accepted accounting practices.

(2) **Individuals with special health care needs (ISHCN):** Individuals who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition, or have low to severe functional limitation and who also require health and relat-

ed services of a type or amount beyond that required by individuals generally.

J - L: [RESERVED]

M. Definitions beginning with letter "M":

(1) **Managed care organization (MCO):** An organization licensed to manage, coordinate and assume financial risk on a capitated basis for the delivery of specified services to enrolled members from a certain geographic area. Also referred to as a managed care plan and managed care program.

(2) **Marketing:** The act or process of promoting a business or commodity. Marketing includes brochures, leaflets, internet, newspaper, magazine, radio, television, billboard materials, MCO/SE yellow page advertisements, and any other presentation materials used by an MCO/SE, MCO/SE representative, or MCO/SE subcontractor to attract or retain medicaid enrollment.

(3) **MCO/SE:** The use of MCO/SE in these medicaid managed care regulations indicates the following regulation applies to both the MCO and the SE who must each comply with the regulation independent of each other.

(4) **MCO/SE mandatory enrollee:** A client whose enrollment into an MCO/SE is mandated.

(5) **Medicaid:** The medical assistance program authorized under Title XIX of the Social Security Act or its successors, furnished to New Mexico residents who meet specific eligibility requirements.

(6) **Medical/clinical home:** A conceptual model that facilitates the provision of quality care that is accessible, family-centered, continuous, coordinated, compassionate and culturally competent.

(7) **Medically necessary services:**

(a) Medically necessary services are clinical and rehabilitative physical or behavioral health services that:

(i) are essential to prevent, diagnose or treat medical conditions or are essential to enable the individual to attain, maintain or regain functional capacity;

(ii) are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical, mental and behavioral health care needs of the individual;

(iii) are provided within professionally accepted standards of practice and national guidelines; and

(iv) are required to meet the physical and behavioral health needs of the individual and are not primarily for the convenience of the individual, the provider or the payer.

(b) Application of the definition:

(i) a determination that a health care service is medically necessary does not mean that the health care service is a covered benefit or an amendment, modification or expansion of a covered benefit;

(ii) the MCO/SE making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the medicaid benefit package applicable to an eligible individual shall do so by: 1) evaluating individual physical and behavioral health information provided by qualified professionals who have personally evaluated the individual within their scope of practice, who have taken into consideration the individual's clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training, as appropriate; 2) considering the views and choices of the individual or the individual's legal guardian, agent or surrogate decision maker regarding the proposed covered service as provided by the clinician or through independent verification of those views; and 3) considering the services being provided concurrently by other service delivery systems;

(iii) physical and behavioral health services shall not be denied solely because the individual has a poor prognosis; required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible individual solely because of the diagnosis, type of illness or condition; and

(iv) decisions regarding benefit coverage for children shall be governed by the EPSDT coverage rules.

(8) **Member:** A client enrolled in an MCO/SE.

(9) **Member month:** A calendar month during which a member is enrolled in an MCO/SE.

(10) **Mi via home and community-based waiver:** The New Mexico self-directed medicaid waiver program that supports New Mexicans with disabilities and the elderly by allowing recipients to be active participants in choosing where and how they live and what services and supports they purchase.

N. Definitions beginning with letter "N":

(1) **National committee for quality assurance (NCQA):** A private national organization that develops quality standards for managed health care.

(2) **Network provider:** An individual provider, clinic, group, association or facility employed by or contracted with an MCO/SE to furnish medical or behavioral health services to the MCO's/SE's members under the provisions of the medicaid managed care contract.

O. [RESERVED]

P. Definitions beginning with letter "P":

(1) **Pend decision:** A prior authorization decision is considered pended when the decision is delayed due to lack of documentation, inability to contact parties involved or other reason which delays finalizing an approval. A decision by an MCO/SE to pend approval does not extend or modify required utilization management decision timelines.

(2) **Performance improvement project (PIP):** An MCO/SE QM program activity must include projects that are designed to achieve significant improvement in clinical or non-clinical care areas. PIPs must involve measurements using objective quality indicators, system intervention to achieve improvement, evaluation of the effectiveness of interventions and activities for increasing or sustaining improvement. Outcomes must be measurable over a period of time.

(3) **Performance measurement (PM):** Data specified by the state that enables the MCO/SE's performance to be determined.

(4) **Plan of care:** A written document including all medically necessary services to be provided by the MCO/SE for a specific member.

(5) **Policy:** The statement or description of requirements.

(6) **Potential enrollee:** A medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO/SE.

(7) **Pregnancy-related services:** Medically necessary medical or surgical services related to pregnancy, including procedures to terminate pregnancy.

(8) **Primary care:** All health services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, physician assistant or certified nurse practitioner.

(9) **Preventive health services:** Services that follow current national standards for prevention including both physical and behavioral health.

(10) **Primary care case management (PCCM):** A medical care model in which clients are assigned to a primary care provider who is responsible for managing the quality, appropriateness, and efficiency of the care they receive. The primary care provider is responsible for furnishing case management services to medicaid eligible recipients that include the location, coordination, and monitoring of primary health care services and the appropriate referral to specialty care services.

(11) **Primary care case manager :** A physician, a physician group practice, an entity that medicaid-eligible recipients employ or arrange with physicians to furnish primary care case management services or, at state option, any of the following:

(a) a physician assistant;

(b) a nurse practitioner; or

(c) a certified nurse midwife.

(12) **Primary care provider (PCP):** A provider who agrees to manage and coordinate the care provided to members in the managed care program.

(13) **Procedure:** Process required to implement a policy.

(14) **Protected behavioral health information:** All of the information from the individual receiving behavioral health services, obtained in conversation or in writing, held in memory or written down, learned by behavioral health professionals in the course of assessment or treatment for mental or emotional problems, substance abuse issues or problems with living and includes the thoughts, opinions, diagnoses and assessments that the behavioral health professional develops based on the information the individual has given.

Q. [RESERVED]

R. Definitions beginning with letter "R":

(1) **Rate cell:** A combination of category of eligibility and demographics used to isolate utilization patterns for the determination of capitation.

(2) **Received but unpaid claims (RBUC):** Claims received by the MCO/SE but not paid affecting appropriate expense and aging accounting categories. Such claims are counted as of the date of receipt by the MCO/SE.

(3) **Reduction of care:** A utilization management staff authorization of the type of service requested by the provider but in lesser amounts or units of service than were originally requested. The authorization is based on the client's physical health (medical needs) or behavioral health (clinical needs).

(4) **Referral:** Any specialty, inpatient, outpatient, or diagnostic services that a physician or physician group orders or arranges, but does not provide directly.

(5) **Reinsurance:** Reinsurance is a proactive financial tool that may be used by an MCO/SE to minimize exposure to losses incurred when members utilize health care services beyond anticipated levels or overall member utilization is greater than expected.

(6) **Risk:** The possibility that revenues of the MCO/SE will not be sufficient to cover expenditures incurred in the delivery of contractual services.

(7) **Routine care:** All care, which is not emergent or urgent.

S. Definitions beginning with letter "S":

(1) **Salud!:** The New Mexico managed care program implemented in 1997, covering children, pregnant women and disabled New Mexicans. Parents of medicaid-eligible children are also covered by medicaid if they meet eligibility requirements.

[~~(1)~~] (2) **Single statewide entity (SE):** The entity selected by the state of New Mexico through the behavioral health collaborative to perform all contract functions defined in the behavioral health request for proposal (RFP). The SE is a single contractor selected to provide all defined service responsibilities statewide, including medicaid behavioral health benefits. The SE will administer both the medicaid managed care and medicaid fee-for-service (FFS) programs for all medicaid behavioral health services. The SE shall be responsible for contracting with providers, paying provider claims, assuring care coordination, conducting utilization review and utilization management activities, assuring quality review and service delivery improvement, credentialing practitioners and provider agencies, privileging practitioners to deliver critical services or service approaches, evaluating and monitoring of service delivery and conducting any other administrative functions necessary to achieve the goals of the collaborative. The SE is the agent of the collaborative and shall "coordinate", "braid" or "blend" the funding, human resources and service capacity available from the various state agencies so as to increase flexibility, maximize available resources and create a seamless single behavioral health service delivery system for New Mexico.

[~~(2)~~] (3) **Subcontract:** A written agreement between the MCO/SE and a third party, or between a subcontractor and another subcontractor, to provide services.

[~~(3)~~] (4) **Subcontractor:** A third party who contracts with the MCO/SE or an MCO/SE subcontractor for the provision of services.

T. Definitions beginning with letter "T":

(1) **Targeted case management:** Services that are aimed specifically at special groups of members like adults with developmental disabilities.

[~~(1)~~] (2) **Terminations of care:** The utilization management review decision made during a concurrent review, which yields a denial, based on the current service being no longer medically necessary.

[~~(2)~~] (3) **Third party:** An individual entity or program, which is or may be, liable to pay all or part of the expenditures for medicaid members for services furnished under a state plan.

(4) **Transition of care:** The process when a member is assisted with access to necessary care when the member moves from one health care practitioner or setting to another as their condition and care needs change.

U. Definitions beginning with letter "U": **Urgent condition:** Acute signs and symptoms, which, by reasonable medical judgment, represent a condition of sufficient severity such that the absence of medical attention within 24 hours could reasonably be expected to result in an emergency condition.

V. Definitions beginning with letter "V": **Value added service:** Any service offered to members by the MCO/SE that is not included in the managed care medicaid benefit package and is not a medicaid funded service, benefit or entitlement under the NM Public Assistance Act.

[8.305.1.7 NMAC - Rp 8.305.1.7 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-08; A, 7-1-09]

8.305.1.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost-effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.

[8.305.1.8 NMAC - Rp 8.305.1.8 NMAC, 7-1-04; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.2 NMAC, Sections 8 and 9 which will be effective on July 1, 2009.

8.305.2.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost-effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.

[8.305.2.8 NMAC - Rp 8.305.2.8 NMAC, 7-1-04; A, 7-1-09]

8.305.2.9 MEMBER EDUCATION: Medicaid members shall be educated about their rights, responsibilities, service availability and administrative roles under the managed care program. Member education is initiated when a member becomes eligible for medicaid and is augmented by information provided by HSD and the managed care organization (MCO) or the single statewide entity [~~SE~~] (SE).

A. **Initial information:** The education of the member is initiated by

the eligibility determination agencies. HSD distributes information about medicaid managed care and the enrollment process to these agencies.

B. **MCO/SE enrollment information:** Once a member is determined to be an MCO/SE mandatory enrollee, HSD will provide to the member information about services included in the MCO/SE benefit package, and the MCOs from which the member can choose to enroll as a member.

C. **Informational materials:** The MCO/SE is responsible for providing members and potential members, upon request, a member handbook and a provider directory. The member handbook and the provider directory shall be available in formats other than English. If there is a prevalent population of [~~5%~~] five percent within the MCO/SE membership, as determined by the MCO/SE or HSD, these materials shall be made available in the language of the identified prevalent population.

(1) The MCO member handbook must include the following:

(a) MCO/SE demographic information, including the organization's hotline telephone number;

(b) information on how to obtain services such as after-hours and emergency services, including the 911 telephone system or its local equivalent;

(c) member bill of rights and member responsibilities, including any restrictions on the member's freedom of choice among network providers;

(d) information pertaining to coordination of care by and with PCPs (within the MCO/SE) as well as information pertaining to transition of care (between the MCOs);

(e) how to obtain care in emergency and urgent conditions and that prior authorization is not required for emergency services;

(f) [~~description~~] the amount, duration and scope of mandatory benefits;

(g) information on accessing behavioral health or other specialty services, including a discussion of the member's rights to self-refer to in-plan and out-of-plan family planning providers and a female member's right to self-refer to a women's health specialist within the network for covered care;

(h) limitations to the receipt of care from out-of-network providers;

(i) a list of services for which prior authorization or a referral is required and the method of obtaining both;

(j) a policy on referrals for specialty care and other benefits not furnished by the member's PCP;

(k) notice to members about the grievance process and about HSD's fair hearing process;

(l) information on the member's right to terminate enrollment and the process for voluntarily disenrolling from the plan;

(m) information regarding advance directives;

(n) information regarding obtaining a second opinion;

(o) information on cost sharing, if any;

(p) how to obtain information, upon request, determined by HSD as essential during the member's initial contact with the MCO, which may include a request for information regarding the MCO's structure, operation, and physician's or senior staff's incentive plans;

(q) populations excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program; [~~and~~]

(r) physical health benefits under the state medicaid plan which are not covered by the contract and how the member will be able to access those benefits;

(s) information regarding the birthing option program; and

(t) language that clearly explains that a Native American Salud! member may self-refer to an Indian health service or a tribal health care facility for services.

(2) The SE member handbook shall include the following:

(a) MCO/SE demographic information, including the organization's hotline telephone number;

(b) information on how to obtain services such as after-hours and emergency services, including the 911 telephone system or its local equivalent;

(c) member bill of rights and member responsibilities, including any restrictions on the member's freedom of choice among network providers;

(d) information pertaining to coordination of care with PCPs;

(e) how to obtain care in emergency and urgent conditions;

(f) description of mandatory benefits;

(g) information on accessing behavioral health services, including a discussion of the member's rights to self-refer;

(h) limitations to the receipt of care from out-of-network providers;

(i) a list of services for which prior authorization or a referral is required and the method of obtaining both;

(j) notice to members about the grievance process and about HSD's fair hearing process;

(k) information regarding advance directives;

(l) information regarding obtaining a second opinion;

(m) information on cost sharing, if any;

(n) how to obtain information, upon request, determined by HSD as essential during the member's initial contact with the SE, which may include a request for information regarding the SE's structure, operation, and physician's or senior staff's incentive plans; and

(o) language that clearly explains that a Native American Salud! member may self-refer to an Indian health service or a tribal health care facility for services.

(3) The provider directory must include the following:

(a) MCO/SE addresses and telephone numbers;

(b) MCO: a listing of primary care and self-refer specialty providers with the identity, location, phone number, and qualifications to include area of special expertise and non-English languages spoken that would be helpful to individuals; MCO contracted specialty providers for self-referral shall include, but not be limited to, [~~family planning providers,~~] urgent and emergency care providers, and Indian health service[~~, other Native American providers and pharmacies~~] and tribal health care providers including hospitals, outpatient clinics, pharmacies and dental clinics;

(c) SE: a listing of behavioral health providers with the name, location, phone number, and qualifications to include area of special expertise and non-English languages spoken that would be helpful to individuals including Indian health service and tribal behavioral health providers; and

(d) the material shall be available in a manner and format that can be easily understood by all identified prevalent populations.

D. **Other requirements:**

(1) The MCO/SE shall provide to enrolled members the member handbook and provider directory within 30 calendar days of enrollment.

(2) The handbook and directory shall be provided, in a comprehensive, understandable format that takes into consideration the special needs population, and is in accordance with federal mandates and meets communication requirements delineated in 8.305.8.15 NMAC, *Member Bill Of Rights*. This information may also be accessible via the internet, and be provided as requested by HSD. The MCO/SE shall have a process in place for notifying potential members and members of the availability of this information in alternate formats.

(3) Oral and sign language interpretation must be made available free of charge to members and to potential members, upon request, and be available in all non-English languages.

(4) The member handbook shall be approved by HSD prior to distribution to

medicaid members. The SE's behavioral health member (or consumer) handbook shall be approved by HSD or its designee prior to distribution [~~by HSD or its designee~~].

(5) Notification of material changes in the administration of the MCO/SE, changes to the MCO's/SE's provider network, significant changes in applicable state law, and any other information deemed relevant by HSD shall be distributed to the members 30 days prior to the intended effective date of the change. In addition, the MCO/SE shall make a good faith effort to give written notice of termination of a contracted provider to affected members within 15 days after receipt or issuance of termination notice.

(6) Notification about any of these changes may be made without reprinting the entire handbook.

(7) The MCO/SE shall notify all members at least once per year of their right to request and obtain member handbooks and provider directories.

E. **MCO/SE policies and procedures on member education:** The MCO/SE shall maintain policies and procedures governing the development and distribution of educational material for members. Policies shall address how members and potential members receive information, the means of dissemination and the content comprehension level and languages of this information. The MCO/SE shall have written policies and procedures regarding the utilization of information on race, ethnicity, and primary language spoken by its membership.

F. **Health education:** The MCO/SE shall provide a continuous program of health education without cost to members. Such a program may include publications (brochures, newsletters), electronic media (films, videotapes), presentations (seminars, lunch-and-learn sessions) and classroom instruction. HSD shall not approve health education materials. The MCO/SE shall provide programs of wellness education, including programs provided to address the social, physical, behavioral and emotional consequences of high-risk behaviors.

G. **Maintenance of toll-free line:** The MCO/SE shall maintain one or more toll-free telephone lines which are accessible 24 hours a day, seven days a week, to facilitate member access to a qualified clinical staff to answer health-related questions. MCO/SE members may also leave voice mail messages to obtain other MCO/SE policy information and to register grievances with the MCO/SE. The MCO/SE shall return the telephone call by the next business day.

H. **Member services meetings:** The MCO/SE shall meet as requested with HSD staff for member services meetings. Member services meetings are held to plan outreach and medicaid enrollment activities and events which will be jointly conducted by the MCO/SE and HSD outreach staff.

[8.305.2.9 NMAC - Rp 8.305.2.9 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.3 NMAC, Sections 8, 9, 10 and 11, which will be effective July 1, 2009.

8.305.3.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost-effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.

[8.305.3.8 NMAC - Rp 8.305.3.8 NMAC, 7-1-04; A, 7-1-09]

8.305.3.9 ELIGIBLE MANAGED CARE ORGANIZATIONS (MCO) AND THE BEHAVIORAL HEALTH SINGLE STATEWIDE ENTITY (SE): The human services department (HSD) shall award risk-based contracts to MCOs and a contract to the single SE with statutory authority to assume risk and enter into prepaid capitation agreements, which meet applicable requirements and standards delineated under state and federal law including [~~Title IV~~] Title V of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973 and the Americans with Disabilities Act.

A. **Procurement process:** HSD shall award risk-based contracts to MCOs/SE using a competitive procurement process that conforms to the terms of the New Mexico Procurement Code. Offerors must submit their responses to the request for proposal in conformity with the requirements specified in the request for proposal. [~~The behavioral health collaborative shall award a contract to a single statewide entity (SE to deliver medicaid behavioral health services to medicaid members.~~]

B. **Contract issuance:** The risk-based contracts shall be awarded for at least a two-year period. Contracts are issued to offerors meeting requirements specified under the terms of the managed care contract.

[8.305.3.9 NMAC - Rp 8.305.3.9 NMAC, 7-1-04; A, 7-1-05; A, 7-1-09]

8.305.3.10 CONTRACT MANAGEMENT: HSD is responsible for management of the medicaid contracts issued to MCOs/SE. HSD shall provide the oversight and administrative functions to ensure [~~MCO~~] MCO/SE compliance with the terms of the medicaid contract. [~~The collaborative or its designee shall provide the oversight and administrative functions to ensure SE compliance with the terms of its contract. HSD, as a member of the collaborative,~~] HSD shall provide oversight of the SE contract as it relates to medicaid behavioral health services, providers and members.

A. **General contract requirements:** The MCO/SE shall meet all specified terms of the medicaid contract with HSD [~~and the collaborative~~] as it relates to medicaid members and services and the Health Insurance Portability and Accountability Act (HIPAA). This includes, but is not limited to, insuring confidentiality as it relates to medical records and any other health and enrollment information that identifies a particular member. The MCO/SE shall be held harmless in conversion to HIPAA electronic transmission formats when delays are the result of implementation issues at HSD.

B. **Subcontracting requirements:** The MCO/SE may subcontract to a qualified individual or organization the provision of any service defined in the benefit package or other required MCO/SE functions with HSD's approval. The MCO/SE shall submit boilerplate contract language and sample contracts for various types of subcontracts for HSD's approval. Any substantive changes to contract templates shall be approved by HSD [~~or the collaborative~~] prior to issuance. The SE may assign, transfer, or delegate to a subcontractor key management functions including, but not limited to, care coordination and universal credentialing with the explicit written approval of HSD [~~and the collaborative~~].

(1) **Credentialing requirements:** The MCO/SE shall maintain policies and procedures for verifying that the credentials of its providers and subcontractors meet applicable standards. The MCO/SE shall assure the prospective subcontractor's ability to perform the activities to be delegated.

(2) **Review requirements:** The MCO/SE shall maintain a fully executed original of all subcontracts and make them accessible to HSD [~~on~~] upon request.

(3) **Minimum requirements (MCO/SE):**

(a) subcontracts shall be executed in accordance with applicable federal and state laws, regulations, policies and rules;

(b) subcontracts shall identify the parties of the subcontract and the parties'

legal basis to [~~operation~~] operate in the state of New Mexico;

(c) subcontracts shall include [~~procedures and criteria for terminating the subcontract~~] the frequency of reporting (if applicable) to the MCO/SE and the process by which the MCO/SE evaluates the subcontractor;

(d) subcontracts shall identify the services to be performed by the subcontractor and the services to be performed under other subcontracts; subcontracts must describe how members access services provided under the subcontract;

(e) subcontracts shall include reimbursement rates and risk assumption, where applicable;

(f) subcontractors shall maintain records relating to services provided to members for 10 years;

(g) subcontracts shall require that member information be kept confidential, as defined by federal or state law, and be HIPAA compliant;

(h) subcontracts shall provide that authorized representatives of HSD have reasonable access to facilities, personnel and records for financial and medical audit purposes;

(i) subcontracts shall include a provision for the subcontractor to release to the MCO/SE any information necessary to perform any of its obligations;

(j) subcontractors shall accept payment from the MCO/SE for any services included in the benefit package and cannot request payment from HSD for services performed under the subcontract;

(k) if subcontracts include primary care, provisions for compliance with PCP requirements delineated in the MCO contract with HSD apply;

(l) subcontractors shall comply with all applicable state and federal statutes, rules and regulations, including the prohibition against discrimination;

(m) subcontracts shall have procedures and criteria for terminating the subcontract, a provision for the imposition of sanctions for inadequate subcontractor performance, and terminating, rescinding, or canceling the contracts for violation of applicable HSD requirements;

(n) subcontracts shall not prohibit a provider or other subcontractor from entering into a contractual relationship with another MCO (MCO only);

(o) subcontracts may not include incentives or disincentives that encourage a provider or other subcontractor not to enter into a contractual relationship with another MCO (MCO only);

(p) subcontracts shall not contain any gag order provisions nor sanctions against providers who assist members in accessing the grievance process or otherwise [~~protecting member's interests~~] act to protect members' interests;

(q) subcontracts shall specify the time frame for submission of encounter data to the MCO/SE;

(r) subcontracts to entities that receive annual medicaid payments of at least $5 million shall include detailed information regarding employee education of the New Mexico and federal False Claims Act; [~~and~~]

(s) subcontracts shall include a provision requiring subcontractors to perform criminal background checks, as required by law, for all individuals providing services;

(t) (MCO only) subcontracts shall include a provision requiring providers to submit claims electronically; transportation, meals, lodging, low volume or low dollar providers may have this requirement waived; and

(u) subcontracts shall include the HSD contractual provisions from the state of New Mexico Executive Order 2007-049 concerning subcontractor health coverage requirements.

(4) **Excluded providers:** The MCO/SE shall not contract with an individual provider, or an entity, or an entity with an individual who is an officer, director, agent, or manager who owns or has a controlling interest in the entity, who has been convicted of crimes specified in Section 1128 of the Social Security Act, excluded from participation in any other state's medicaid [~~program~~], medicare, or any other public or private health or health insurance program, assessed a civil penalty under the provision of Section 1128, or who has a contractual relationship with an entity convicted of a crime specified in Section 1128.

C. **Provider incentive plans:** The MCO/SE shall ensure that direct or indirect incentives offered in the subcontract shall not serve as an inducement to reduce or limit medically necessary services to members.

[8.305.3.10 NMAC - Rp 8.305.3.10 NMAC, 7-1-04; A, 7-1-05; A, 9-1-06; A, 7-1-07; A, 7-1-08; A, 7-1-09]

8.305.3.11 ORGANIZATIONAL REQUIREMENTS:

A. **Organizational structure:** The MCO/SE shall provide the following information to HSD and updates, modifications, or amendments to HSD within 30 days:

(1) current written charts of organization or other written plans identifying organizational lines of accountability;

(2) articles of incorporation, bylaws, partnership agreements, or similar documents that describe the MCO's/SE's mission, organizational structure, board and committee composition, mechanisms to select officers and directors and board and public meeting schedules; and

(3) documents describing the MCO's/SE's relationship to parent affiliated and related business entities including, but not limited to, subsidiaries, joint ventures or sister corporations.

B. **Policies, procedures and job descriptions:** The MCO/SE shall establish and maintain written policies, procedures and job descriptions as required by HSD. The MCO/SE shall establish, maintain and implement guidelines for developing, reviewing and approving policies, procedures and job descriptions. The MCO/SE shall provide MCO/SE policies, procedures and job descriptions for key personnel and guidelines for review to HSD, or its designee on request. The MCO/SE shall notify HSD within 30 days when changes in key personnel occur.

(1) **Review of policies and procedures:** The MCO/SE shall review the MCO's/SE's policies and procedures at least every two years, unless otherwise specified herein, to ensure that they reflect the MCO's/SE's current best industry practices. Job descriptions shall be reviewed to ensure that current employee duties reflect written requirements. Modifications or amendments to current policies, procedures or job descriptions of key positions shall be made using the guidelines delineated during the procurement process. Substantive modification or amendment to key positions must be reviewed by HSD.

(2) **Distribution of information:** The MCO/SE shall distribute to providers information necessary to ensure that providers meet all contract requirements.

(3) **Business requirements:** The MCO/SE shall have the administrative, information and other systems in place necessary to fulfill the terms of the medicaid managed care contracts. Any change in identified key MCO/SE personnel shall conform to the requirements of the managed care contract. The MCO/SE shall retain financial records, supporting documents, statistical records, and all other records for a period of 10 years from the date of submission of the final expenditure report, except as otherwise specified in writing by HSD.

(4) **Financial requirements:** The MCO/SE shall meet minimum requirements delineated by federal and state law with respect to solvency and performance guarantees for the duration of the contract. In addition, the MCO/SE shall meet additional financial requirements specified in the contract.

(5) **Member services:** The MCO/SE shall have a member services function that coordinates communication

with members and acts as a member advocate. Member services shall include sufficient staff to assist members in resolving problems or making inquiries. The MCO's/SE's policies and procedures shall be made available on request to members or member representatives for review during normal business hours.

(6) **Consumer advisory board:** The MCOs and the SE shall establish their respective consumer advisory board that includes regional representation of consumers, family members, advocates and providers. [~~The SE's behavioral health consumer advisory board shall also interact with the behavioral health planning council (BHPC) as directed by the collaborative.~~] The MCO and the SE consumer advisory boards shall interface and collaborate with one another as appropriate. If the formation of a separate SCI consumer advisory board is deemed impractical because of enrollment of less than 2,500 members, the MCO shall include at least three SCI members in the Salud! consumer advisory board meetings.

(a) The MCO consumer advisory board members shall serve to advise the MCO on issues concerning service delivery and quality of service, the member bill of rights and member responsibilities, resolution of member grievances and the needs of groups represented by board member as they pertain to medicaid, including managed care. The SE consumer advisory board members shall serve to advise the SE on issues concerning service delivery and quality of service, the member bill of rights and member responsibilities, resolution of member grievances and the needs of groups represented by board member as they pertain to medicaid, including managed care. [~~The MCO and the SE board shall meet at least quarterly and keep a written record of meetings.~~] The MCO/SE shall hold quarterly, centrally located meetings every year. The [~~board~~] attendance roster and minutes shall be made available to HSD on request. The [~~MCO~~] MCO/SE shall advise HSD 10 days in advance of meetings to be held. HSD shall attend and observe the [~~MCOs'~~] MCO's consumer advisory board meetings at their discretion. HSD shall attend and observe the SE's consumer advisory board meetings at its discretion.

(b) The SE shall attend at least two statewide consumer driven or hosted meetings per year, of the SE's choosing, that focus on consumer issues and needs, to ensure that members' concerns are heard and addressed. The MCO will hold at least two additional statewide consumer advisory board meetings each contract year that focus on consumer issues to help ensure that consumer issues and concerns are heard and addressed. Attendance rosters and minutes for these two statewide meetings shall be made available to HSD.

(7) **Requirements for Native American membership:** Per HSD direction, the MCO shall hold at least one annual meeting with Native American representatives from around the state of New Mexico that represent geographic and member diversity. The minutes of such meetings shall be submitted to HSD within 30 days of such meetings.

[~~(7)~~] (8) **Contract enforcement:** HSD shall enforce contractual and state and federal regulatory requirements specified in the scope of work of the contract. HSD may use the following types of sanctions for less than satisfactory or nonperformance of contract provisions:

(a) require plans of correction;

(b) impose directed plans of correction;

(c) impose monetary penalties or sanctions to the extent authorized by federal or state law:

(i) HSD retains the right to apply progressively stricter sanctions against the MCO/SE, including an assessment of a monetary penalty against the MCO/SE, for failure to perform in any contract area;

(ii) unless otherwise required by law, the level of sanctions shall be based on the frequency or pattern of conduct, or the severity or degree of harm posed to or incurred by members or the integrity of the medicaid program;

(iii) a monetary penalty, depending upon the severity of the infraction; penalty assessments shall range up to [~~5%~~] five percent of the MCO's/SE's medicaid capitation payment for each month in which the penalty is assessed;

(iv) any withholding of capitation payments in the form of a penalty assessment does not constitute just cause for the MCO/SE to interrupt services provided to members; and

(v) all administrative, contractual or legal remedies available to HSD shall be employed in the event that the MCO/SE violates or breaches the terms of the contract;

(d) impose other civil or administrative monetary penalties and fines under the following guidelines:

(i) a maximum of $25,000.00 for each of the following determinations: failure to provide service; misrepresentation or false statements to members, potential members, or health care providers; failure to comply with physician incentive plan requirements; and marketing violations;

(ii) a maximum of $100,000.00 for each of the following determinations: discrimination or misrepresentation or false statements to HSD or CMS;

(iii) a maximum of $15,000.00 for each member HSD determines was not enrolled, or reenrolled, or enrollment was terminated because of a discriminatory practice; this is subject to an overall limit of $100,000.00 under (ii) above;

(iv) a maximum of $25,000.00 or double the amount of the excess charges, whichever is greater, for premiums or charges in excess of the amount permitted under the medicaid program; the state must deduct from the penalty the amount of overcharge and return it to the affected enrollees;

(e) adjust automatic assignment formula;

(f) rescind marketing consent;

(g) suspend new enrollment, including default enrollment after the effective date of the sanction;

(h) appoint a state monitor, the cost of which shall be borne by the MCO/SE;

(i) deny payment;

(j) assess actual damages;

(k) assess liquidated damages;

(l) remove members with third party coverage from enrollment with the MCO/SE;

(m) allow members to terminate enrollment;

(n) suspend agreement;

(o) terminate MCO/SE contract;

(p) apply other sanctions and remedies specified by HSD; and

(q) impose temporary management only if it finds, through on-site survey, enrollee complaints, or any other means that;

(i) there is continued egregious behavior by the MCO/SE, including but not limited to, behavior that is described in Subparagraph (d) above, or that is contrary to any requirements of 42 USC Sections 1396b(m) or 1396u-2; or

(ii) there is substantial risk to member's health; or

(iii) the sanction is necessary to ensure the health and safety of the MCO's/SE's members while improvement is made to remedy violations made under Subparagraph (d) above; or until there is orderly termination or reorganization of the MCO/SE;

(iv) HSD shall not delay the imposition of temporary management to provide a hearing before imposing this sanction; HSD shall not terminate temporary management until it determines that the MCO/SE can ensure that the sanction behavior will not re-occur; refer to state and federal regulations for due process procedures.

[8.305.3.11 NMAC - Rp 8.305.3.11 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-08; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.4 NMAC, Sections 8, 9 and 10, which will be effective July 1, 2009.

8.305.4.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.
[8.305.4.8 NMAC - N, 7-1-01; A, 7-1-09]

8.305.4.9 MANAGED CARE ELIGIBILITY: HSD determines eligibility for enrollment in the managed care program. All medicaid eligible clients are required to participate in the medicaid managed care program except for the following:

A. clients eligible for both medicaid and medicare (dual eligibles);

B. institutionalized clients, defined as those expected to reside in a nursing facility for long term care or permanent placement; this does not include clients placed in a nursing facility to receive subacute or skilled nursing care in lieu of continued acute care;

C. clients residing in intermediate care facilities for the mentally retarded;

D. clients participating in the health insurance premium payment (HIPP) program;

E. children and adolescents in out-of-state foster care or adoption placements;

F. Native Americans;

G. clients eligible for medicaid category 029, family planning services only;

H. women eligible for medicaid category 052, breast and cervical cancer program [~~,and members approved for the disabled and elderly home and community based waiver~~];

I. adults ages 19-64 eligible for category 062, state coverage insurance;

J. members with brain injury COE 092; [~~and~~]

K members approved for adult personal care options (PCO) services; and

L. members approved for the disabled and elderly home and community-based waiver categories 091, 093 and 094.

[8.305.4.9 NMAC - Rp 8 NMAC 4.MAD.606.3.1, 7-1-01; A, 7-1-02; A, 7-1-04; A, 7-1-05; A, 7-1-08; A, 7-1-09]

8.305.4.10 SPECIAL SITUATIONS:

A. **Newborn enrollment:** The following provisions apply to newborns:

(1) Medicaid eligible and enrolled newborns of medicaid eligible enrolled mothers are eligible for a period of 12 months starting with the month of birth. These newborns are enrolled retroactive to the date of birth with the same MCO the mother had during the birth month, as soon as the newborn's eligibility is approved, regardless of where the child is born (that is, in the hospital or at home). The MCO is responsible for care of a newborn to a Salud! enrolled mother, whose eligibility is determined through daily rosters provided by [~~HSD/MAD~~] HSD or by the MCO's required follow-up of the MAD 313 form.

(2) If the newborn's mother is not a member of the MCO at the time of the birth in a hospital or at home, the newborn must be medicaid enrolled and shall be MCO enrolled during the next applicable enrollment cycle.

B. **Hospitalized members:** Regarding Salud! MCO and medicaid fee-for-service (FFS) members: If an MCO or FFS member is hospitalized at the time of enrollment into or disenrollment from managed care or upon an approved switch from one MCO to another, [~~with the exception of a member transferring to CLTS,~~] the originating MCO or FFS shall be responsible for payment of all covered inpatient facility and professional services provided within a licensed acute care facility, or a non-psychiatric specialty unit or hospitals as designated by the New Mexico department of health. The payer at the date of admission remains responsible for the services until the date of discharge. [~~Services provided at a free-standing psychiatric hospital or within a psychiatric unit of an acute care hospital are the responsibility of the SE.~~] Upon discharge, the member will then become the financial responsibility of the organization or entity receiving capitation payments or FFS in the case of disenrollment from Salud! Regarding Salud!MCO and CoLTS MCO members: For members transitioning to [~~CLTS~~] or from CoLTS, the originating MCO shall be responsible for payment of all covered inpatient facility and professional services up to the date of disenrollment from Salud! to CoLTS or disenrollment from CoLTS to Salud! For either transition, services provided at a free-standing psychiatric hospital or within a psychiatric unit of an acute care hospital are the responsibility of the SE. This does not apply to newborns born to a member mother; see Subsection A of 8.305.4.10 NMAC above. [~~Transition services, e.g., DME supplies for the home, shall be the financial responsibility of the MCO or the SE, if applicable to behavioral health receiving capitation payments.~~] The originating and receiving organization are both required to ensure continuity and coordination of care during the transition.

C. **Native Americans:** A self-identified Native American shall be afforded the option of participating in managed care or being covered by medicaid fee-for-service for medical or behavioral health services. Upon determination of medicaid eligibility, a Native American may choose to participate in managed care, or opt in, by enrolling in an MCO for medical services or by choosing the managed care SE for behavioral health services. By not enrolling in an MCO or not choosing the managed care SE, the Native American chooses not to participate in managed care and shall be covered through medicaid fee-for-service. A medicaid eligible Native American may opt-in at any time by enrolling with an MCO or by choosing the managed care SE. If an opt-in request is made prior to the 20th of the month, the opt-in shall become effective the following month. If the opt-in request is made after the 20th of the month and before the first day of the next month, the opt-in shall be effective on the first day of the second full month following the request. After enrolling in an MCO or the managed care SE, a Native American may opt out during the first 90 days of any 12-month enrollment lock-in period (disenrollment). Disenrollment is effective the following month. At the end of the lock-in period, a Native American may choose to either continue enrollment in managed care or opt-out of managed care.

D. **Members receiving hospice services:** Members who have elected to receive hospice services and are receiving hospice services at the time they are determined eligible for medicaid will be exempt from enrolling in managed care unless they revoke their hospice election.

E. **Members placed in nursing facilities:** If a member is placed in a nursing facility for what is expected to be a long term or permanent placement, the MCO or the SE, remains responsible for the member until the member is disenrolled [~~by HSD~~] from Salud! and enrolled into the CoLTS program at the time that the nursing facility determination (the approved abstract) is entered into the MMIS system. Failure of a nursing facility to maintain abstract authorization for an institutionalized member that causes the system to enroll the member into managed care is considered an error in enrollment. The MCO/SE is not responsible for payment of any medical or behavioral services delivered and all capitations shall be recouped.

F. **Members in third trimester of pregnancy:** A woman in her third trimester of pregnancy at the time of enrollment, who has an established obstetrical provider may continue that relationship. Refer to Paragraph (4) of Subsection H of 8.305.11.9 NMAC for special payment requirements.

G. **Members placed in institutional care facilities for the mentally retarded (ICF/MR):** If a member is placed in an ICF/MR for what is expected to be a long-term or permanent placement, the MCO/SE remains responsible for the member until the member is disenrolled by HSD.

[~~H. In compliance with federal law and authorizations, HSD may mandate that a member eligible for medicaid and medicare (dual eligibles) shall be enrolled with an MCO/SE to receive benefits from the medicaid benefit package that are not provided by medicare. This program will be implemented in compliance with federal law and requirements.~~]

[8.305.4.10 NMAC - Rp 8 NMAC 4.MAD.606.3.2, 7-1-01; A, 7-1-04; A, 7-1-05; A, 9-1-06; A, 7-1-07; A, 7-1-08; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.5 NMAC, Sections 8, 9, 11, 12, and 13, which will be effective July 1, 2009.

8.305.5.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost-effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.

[8.305.5.8 NMAC - Rp 8.305.5.8 NMAC, 7-1-04; A, 7-1-09]

8.305.5.9 ENROLLMENT PROCESS.

A. **Enrollment requirements:** The managed care organization (MCO) shall provide an open enrollment period during which the MCO shall accept eligible individuals in the order in which they apply without restriction, unless authorized by the CMS regional administrator, up to the limits contained in the contract. The MCO shall not discriminate on the basis of health status or a need for health care services. The MCO shall not discriminate against individuals eligible to enroll on the basis of race, color, national origin, or sexual orientation and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, or sexual orientation. All enrollments in a specific MCO shall be member choice. Enrollment in the SE is mandatory for all members enrolled in managed care or medicaid fee-for-service.

B. **Selection period:** The member shall have [~~14~~] at least 16 calendar days to select an MCO. If a selection is not made [~~in 14 days~~], the member shall be assigned to an MCO by HSD. Members mandated into managed care shall be automatically assigned to the SE.

C. **Enrollment methods when no selection made:**

(1) **Enrollment with previous MCO:** The member is automatically enrolled with the previous MCO unless the MCO is no longer in good standing, is no longer contracting with HSD or has had enrollment suspended.

(2) **Enrollment based on case continuity:** Enrollment based on case continuity is applied in the following manner:

(a) **Processing case continuity:** The member is enrolled with the MCO to which the majority of the case (family) members [~~is~~] are assigned. If an equal number of case (family) members are assigned to different MCOs and a majority cannot be identified, the member is assigned to an MCO to which other case (family) members are assigned.

(b) **Newborn enrollment:** [~~A newborn whose mother is a member in an MCO is automatically enrolled in the mother's MCO and in the SE.~~] When a child is born to a mother enrolled with a Salud! MCO, hospitals or other providers shall complete a notification of birth, MAD Form 313. The newborn remains enrolled with the mother's MCO until the mother selects a new MCO for the child.

(3) **Percentage-based assignment (assignment algorithm):** As determined by HSD, members who are not enrolled using the previous methods may be enrolled in an MCO using a percentage-based assignment process. The percentage-based assignments for each MCO may be determined based upon consideration of the MCO's performance in such areas as the quality assurance standards, encounter data submissions, reporting requirements, third party liability collections, marketing plan, community relations, coordination of service, grievance resolution, claims payment, price and consumer input.

D. **Begin date of enrollment:** Enrollment begins the first day of the first full month following selection or assignment except in the following circumstances:

(1) newborn enrollment (Subsection A of 8.305.4.10 NMAC, *newborn enrollment*); and

(2) members receiving hospice care (Subsection E of 8.305.4.10 NMAC, *members receiving hospice services*)[~~,and~~]

[~~(3) if the selection or assignment is made after the 25th day of the month and before the first full day of the following month, the enrollment begins on the first day of the second month after the selection or assignment~~].

E. **Member lock-in:** Member enrollment in an MCO runs for a 12-month cycle. During the first 90 days after a member initially selects or is assigned to an MCO, the member shall have the option to choose a different MCO to provide care during the member's remaining period of managed care enrollment.

(1) If the member does not choose a different MCO, the member will continue to receive care from the MCO that provided the member's care in the first 90 days.

(2) If, during the member's first 90 days with an MCO, he chooses a different MCO, the member will have a 90-day open enrollment period with this new MCO.

(3) After exercising his switching rights, and returning to a previously selected MCO, the member shall remain with this MCO until his 12-month lock-in period expires before being permitted to switch MCOs.

(4) At the conclusion of the 12-month cycle, the member shall have the same choices offered at the time of initial enrollment. The member shall be notified 60 days prior to the expiration date of the member's lock-in period of the expiration of the lock-in and the deadline by when to choose a new MCO.

(5) If a member loses medicaid eligibility for a period of two months or less, he will be automatically reenrolled with the former MCO. If the member misses the annual disenrollment opportunity during this two-month time, he may request to be assigned to another MCO.

F. **Member switch enrollment:** A member who is required to enroll in managed care may request to be disenrolled from an MCO and switch to another MCO "for cause" at any time. The member or his representative shall make the request in writing to HSD. HSD shall review the request and furnish a written response to the member and the MCO no later than the first day of the second month following the month in which the member or his representative files the request. If HSD fails to make a disenrollment determination so that the member may be disenrolled during this timeframe, the disenrollment is considered approved. A member who is denied disenrollment shall have access to HSD's fair hearing process. The following criteria shall be cause for disenrollment:

(1) continuity of care issues;

(2) family continuity;

(3) administrative or data entry error in assigning a member to an MCO;

(4) assignment of a member where travel for primary care exceeds community standards (90[~~%~~] percent of urban residents shall travel no further than 30 miles to see a PCP; 90[~~%~~] percent of rural residents shall travel no further than 45 miles to see a PCP; and 90[~~%~~] percent of frontier residents shall travel no further than 60 miles to see a PCP); urban counties are: Bernalillo, Los Alamos, Santa Fe and Dona Ana; frontier counties are: Catron, Harding, DeBaca, Union, Guadalupe, Hidalgo, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, San Miguel and Cibola; rural counties are those which are not listed as urban or frontier;

(5) the member moves out of the MCO service area;

(6) the MCO does not, because of moral or religious objections, cover the service the member seeks;

(7) the member needs related services to be performed at the same time, not all related services can be provided by the PCP, and another provider determines that receiving the services separately would subject the member to unnecessary risk; and

(8) other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs.

G. **Exemption:** HSD shall grant exemptions to mandatory enrollment on a case-by-case basis. HSD shall grant exemptions to mandatory enrollment for medicaid managed care physical health and behavioral health services for cause on a case-by-case basis. If the exemption is granted, the member shall receive [~~his~~] the member's behavioral health services through the SE under the medicaid fee-for-service (FFS) program and the member's physical health services under the medicaid FFS program. A member or the member's representative, parent or legal guardian shall request exemption in writing to HSD, describing the special circumstances that warrant an exemption. Alternatively, HSD may initiate an exemption on a case-by-case basis. Requests for exemption shall be evaluated by HSD clinical staff and forwarded to the medical assistance division medical director or designee for final determination. Members shall be notified of the disposition of exemption requests. A member requesting an exemption, who is not enrolled in managed care at the time of the exemption request, shall remain exempt until a final determination is made. A member already in managed care at the time of the exemption request shall remain in managed care until a final determination is made. HSD shall review the request and furnish a written response to the member no later than the first day of the second month following the month in which the member files the request. If HSD fails to make a determination so that the member may become exempt within this timeframe, the exemption is considered approved. A member who is denied exemption shall have access to HSD's fair hearing process.

H. **Disenrollment, MCO/SE initiated:** The MCO/SE may request that a particular member be disenrolled from managed care. Member disenrollment from an MCO/SE shall be considered in rare circumstances. Disenrollment requests shall be made in writing to HSD. The request and supporting documentation shall meet HSD conditions stated below in Subsection I of 8.305.5.9 NMAC, *conditions under which an MCO/SE may request member disenrollment*. The MCO/SE shall not request disenrollment because of an adverse change in the member's health status or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his special needs (except when his continued enrollment with the MCO/SE seriously impairs the MCO's or SE's ability to furnish services to either this particular member or other members). The MCO/SE shall notify the member in writing of the disenrollment request at the same time the request is submitted to HSD. The MCO/SE shall submit a copy of the member's notification letter to HSD. If the disenrollment is granted, the MCO/SE retains responsibility for the member's care until the member is enrolled with another MCO or exempted from managed care. In the case of the SE, the member would be exempted from the SE medicaid managed care and would receive behavioral health benefits under the medicaid fee-for-service (FFS) program. The MCO/SE shall assist with transition of care.

I. **Conditions under which an MCO/SE may request member disenrollment:** Conditions under which an MCO/SE may request disenrollment are:

(1) the MCO/SE demonstrates a good faith effort has been made to accommodate the member and address the member's problems, but those efforts have been unsuccessful;

(2) the conduct of the member does not allow the MCO/SE to safely or prudently provide medical or behavioral health care subject to the terms of the contract;

(3) the MCO/SE has offered to the member in writing the opportunity to use the grievance procedures; and

(4) the MCO/SE has received threats or attempts of intimidation from the member to the MCO's or SE's providers or MCO/SE staff.

J. **Re-enrollment limitations:** If a request for disenrollment is approved, the member shall not be re-enrolled with the requesting MCO for a period of time to be determined by HSD. The member and the requesting MCO shall be notified by HSD of the period of disenrollment. If a member has been disenrolled by all contracted MCOs, HSD shall evaluate the member for medical management. In the case of the SE, the member would be exempted from the SE medicaid managed care and would receive behavioral health benefits under the medicaid fee-for-service (FFS) program.

K. **Date of disenrollment:** MCO/SE enrollment, upon approval, shall terminate at the end of a calendar month.

[8.305.5.9 NMAC - Rp 8.305.5.9 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.5.11 MEMBER IDENTIFICATION CARD: The MCO shall issue a member identification card with SE contact information within 30 days of enrollment to each member. HSD shall review and approve the identification card. The card shall be substantially the same as the card issued to commercial enrollees. The card shall not contain information that identifies the member as a medicaid recipient, other than designations commonly used by MCOs to identify for providers the members' benefits, such as group or plan numbers.

[8.305.5.11 NMAC - Rp 8.305.5.14 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.5.12 MASS TRANSFER PROCESS: The mass transfer process is initiated when HSD determines that the transfer of MCO members from one MCO to another is appropriate.

A. **Triggering mass transfer process:** The mass transfer process may be triggered by two situations:

(1) a maintenance change, such as changes in MCO identification number or MCO name; and

(2) a significant change in MCO contracting status, including but not limited to, loss of licensure, substandard care, fiscal insolvency or significant loss in network providers.

B. **Effective date of mass transfer:** The change in enrollment initiated by the mass transfer begins with the first day of the month following the identification of the need to transfer MCO members.

[~~C. **Member selection period:** Following a mass transfer, MCO members are given an opportunity to select a different MCO.~~]

[~~D.~~] C. **Mass transfer based on maintenance:** The mass transfer maintenance function may be triggered when the medicaid or managed care status change of the MCO is transparent to the member. For instance, a change in the MCO's medicaid identification number is a system change that requires a mass transfer but is not relevant to the member and service continues with the MCO. Upon initiation of the maintenance function by HSD, members are automatically transferred to the prior MCO experiencing the maintenance change.

[~~E.~~] D. **Mass transfer based on significant change in contracting status:** The mass transfer function is triggered when the MCO's contract status changes and the change may be significant to the MCO member. Upon initiation of the mass transfer function by HSD, [~~MCO members are transferred to the "transfer to" MCO and~~] a notice is sent to members informing them of the transfer and their opportunity to select a different MCO.

[8.305.5.12 NMAC - Rp 8.305.5.15 NMAC, 7-1-04; A, 7-1-05; A, 7-1-09]

8.305.5.13 MEDICAID MANAGED CARE AND SINGLE STATEWIDE ENTITY MARKETING GUIDELINES: When marketing to medicaid members, the MCOs/SE shall follow the medicaid managed care marketing guidelines.

A. **Minimum marketing and outreach requirements:** Marketing is defined as the act or process of promoting a business or commodity**.** The marketing and outreach material must meet the following minimum requirements:

(1) marketing and outreach materials must meet requirements for all communication with medicaid members, as delineated in the quality standards (8.305.8.15 NMAC, *member bill of rights*) and incorporated into the managed care contract;

(2) all marketing or outreach materials produced by the MCO/SE under the medicaid managed care contract shall state that such services are funded in part under contract with the state of New Mexico;

(3) marketing and outreach information provided to members shall be accurate, not misleading, and non-threatening;

(4) if there is a prevalent population of [~~5%~~] five percent in the MCO/SE membership that has limited English proficiency, as identified by the MCO/SE or HSD, marketing materials must be available in the language of the prevalent population; and

(5) other requirements specified by the state.

B. **Scope of marketing guidelines:** Marketing materials are defined as brochures and leaflets, newspaper, magazine, radio, television, billboard, MCO/SE yellow page [~~advertisement, web site~~] advertisements, web site, press releases, telephone scripts and presentation materials used by an MCO/SE, [~~and~~] an MCO/SE representative or an MCO/SE sub-contractor to attract or retain medicaid enrollment. HSD may request, review and approve or disapprove any communication to any medicaid member. HSD may request, review and approve or disapprove any communication to any medicaid member regarding behavioral health. The MCO/SE [~~are~~] is not restricted by HSD in their general communications to the public. HSD shall approve advertisements mailed to, distributed to, or aimed at medicaid members and marketing material that mentions medicaid, medical assistance, Title XIX or makes reference to medicaid behavioral health services. The MCO/SE shall notify HSD of significant format changes to advertisements. Examples of medicaid-specific materials would be those that:

(1) are in any way targeted to medicaid populations, such as billboards or bus posters disproportionately located in low-income neighborhoods;

(2) mention the MCO/SE's medicaid product name; or

(3) contain language or information designed to attract medicaid enrollment.

C. **Advertising and marketing material:** The dissemination of medicaid-specific advertising and marketing materials, including materials disseminated by a sub-contractor and information disseminated via the internet requires the approval of HSD or its designee. In reviewing this information, HSD shall apply a variety of criteria.

(1) **Accuracy:** The content of the material must be accurate. Information deemed inaccurate shall be disallowed.

(2) **Misleading references to MCO/SE strengths:** Misleading information shall not be allowed even if it is accurate. For example, an MCO/SE may seek to advertise that its health care services, including behavioral health, are free to medicaid members. HSD would not allow the language because it could be construed by members as being a particular advantage of the MCO/SE. In other words, they might believe they would have to pay for medicaid health services if they chose another MCO or remained in fee-for-service medicaid.

(3) **Threatening messages:** An MCO/SE shall not imply that another managed care or other behavioral health program is endangering members' health status, personal dignity or the opportunity to succeed in various aspects of their lives. An MCO/SE may differentiate itself by promoting its legitimate strengths and positive attributes, but not by creating threatening implications about the mandatory assignment process or other aspects of the program.

D. **Marketing and outreach activities not permitted:** The following marketing and outreach activities are not permitted regardless of the method of communication (oral, written or other means of communication) or whether the activity is performed by the MCO/SE directly, its network providers, its subcontractors or any other party affiliated with the MCO/SE. HSD shall prohibit additional marketing activities at its discretion.

(1) asserting or implying that a member will lose medicaid benefits if he does not enroll with the MCO or creating other scenarios that do not accurately depict the consequences of choosing a different MCO;

(2) designing a marketing or outreach plan that discourages or encourages MCO selection based on health status or risk;

(3) initiating an enrollment request on behalf of a medicaid member except under circumstances in which the MCO, its representative, network provider or subcontractor may perform presumptive eligibility screening or medicaid onsite application assistance as an agent of the state;

(4) making inaccurate, misleading or exaggerated statements designed to recruit a potential member;

(5) asserting or implying that the MCO offers unique covered services where another MCO provides the same or similar services;

(6) the use of more than nominal gifts such as diapers, toasters, infant formula or other incentives to entice medicaid members to join a specific health plan;

(7) telemarketing or door-to-door marketing with potential members;

(8) conducting any other marketing activity prohibited by HSD or its designee;

(9) explicit direct marketing to members enrolled with other MCOs unless the member requests the information;

(10) distributing any marketing materials without first obtaining the approval of HSD or its designee;

(11) seeking to influence enrollment in conjunction with the sale or offering of any private insurance;

(12) engaging in telephone or other cold call marketing activities, directly or indirectly; and

(13) other requirements specified by HSD[~~;~~

~~(14) initiating an enrollment request on behalf of a medicaid recipient except under circumstances in which the MCO, its representative, network provider~~

~~or subcontractor may perform presumptive eligibility screening or medicaid on site application assistance as an agent of the state~~].

E. **Marketing in current care sites:** Promotional materials may be made available to members and potential MCO/SE enrollees in care delivery sites, including patient waiting areas, if HSD has prior approved the content. Face-to-face meetings at care delivery sites for the purpose of marketing to potential MCO/SE enrollees by MCO/SE staff shall not be permitted.

F. **Provider communications with medicaid members about MCO/SE options:** HSD marketing restrictions shall apply to MCO/SE subcontractors and providers as well as to the MCO/SE. The MCO/SE is required to notify participating providers of the HSD marketing restrictions, including providing a copy of these regulations. HSD shall not review yellow page ads of individual providers, unless specifically requested to do so.

G. **Member-initiated meetings with MCO/SE staff prior to enrollment:** Face-to-face meetings requested by a member are permitted. These meetings may occur at a mutually agreed upon site. All verbal interaction with the member must be in compliance with the guidelines identified in these regulations.

H. **Mailings by the MCO/SE:** MCO/SE mailings shall be permitted in response to a member's oral or written request for information. The content of marketing or promotional mailings shall be prior approved by HSD or its designee. MCO/SE may, with HSD approval, provide potential members with information regarding the MCO/SE medicaid benefit package. MCO/SE shall not send gifts however nominal in value, in these mailings. MCO/SE may send solicited and unsolicited mailings to members and potential members. Unsolicited mailings are defined as: newsletters; notification of outreach events and member services meetings; educational materials and literature related to the MCO/SE preventive medicine initiatives, (such as, diabetes screening, drug and alcohol awareness, and mammograms). HSD shall approve the content of mailings except health education materials. The target audience of the mailings shall be prior approved by HSD or its designee.

I. **Group meetings:** The MCO/SE may hold public meetings. HSD shall be furnished with notice of the meetings and shall prior approve any marketing material to be presented at the meeting. HSD, or its designee shall approve the methodology used by the MCO/SE to solicit attendance for the public meetings. HSD or its designee may attend the meeting.

J. **Light refreshments for members at meetings:** The MCO/SE may offer light refreshments at approved group meetings. The availability of food and beverages shall not be mentioned in advertisements for the meetings. *Alcoholic beverages shall not be offered at meetings.*

K. **Gifts, cash incentives or rebates to members:** The MCO/SE and their providers, with HSD approval, may disseminate marketing materials, including nominal gifts such as pens, key chains and magnets to potential members.

L. **Gifts to members at health milestones unrelated to enrollment:** Members may be given "rewards" for accessing care, such as a baby T-shirt when a woman completes a targeted series of prenatal visits. Items that reinforce a member's healthy behavior, (car seats, infant formula, magnets and telephone labels) that advertise the member services hotline and the PCP office telephone number for members are examples of "rewards". HSD shall approve gifts with a retail value of over $25.00. Health education videos may be provided. HSD encourages MCOs/SE to include reward items in information sent to new MCO/SE members.

M. **Marketing time frames:** The MCO/SE may initiate marketing and outreach activities at any time.

[8.305.5.13 NMAC - Rp 8.305.5.16 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-08; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.6 NMAC, Sections 8, 9, 12 and 18, which will be effective July 1, 2009.

8.305.6.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.

[8.305.6.8 NMAC - N, 7-1-01; A, 7-1-09]

8.305.6.9 GENERAL NETWORK REQUIREMENTS: The MCO/SE shall establish and maintain a comprehensive network of providers willing and capable of serving members enrolled with the MCO/SE.

A. **Service coverage:** The MCO/SE shall provide or arrange for the provision of services described in 8.305.7 NMAC, *Benefit Package*, in a timely manner. The MCO/SE is solely responsible for the provision of covered services and must ensure that its network includes providers in sufficient numbers and required specialists to make all services included in the package available and in accordance with access standards.

B. **Comprehensive network:** The MCO/SE shall contract with the full array of providers necessary to deliver a level of care at least equal to, or better than, community norms. The MCO/SE shall contract with a number of providers sufficient to maintain equivalent or better access than that available under medicaid fee-for-service. The MCO/SE shall take into consideration the characteristics and health care needs of its individual medicaid populations. The MCO/SE must contractually require that all network providers and subcontractors be in compliance with the Health Insurance Portability and Accountability Act (HIPAA). In establishing and maintaining the network of appropriate providers, the MCO/SE shall consider the following:

(1) the numbers of network providers who are not accepting new medicaid members, as identified by checking the open/closed panel status;

(2) the geographic location of providers and medicaid members, considering distance, travel time, the means of transportation ordinarily used by medicaid members; and

(3) whether the location provides physical access for medicaid members, including members with disabilities.

C. **Maintenance of provider network:** The MCO/SE shall notify HSD within five working days of unexpected changes to the composition of its provider network that negatively affects members' access or the [~~MCO/SE's~~] MCO's/SE's ability to deliver services included in the benefit package in a timely manner. The MCO/SE shall regularly update open and closed panel status and post this information on their website. Anticipated material changes in an MCO/SE provider network shall be reported to HSD in writing within 30 days prior to the change, or as soon as the MCO/SE knows of the anticipated change. A notice of significant change must contain:

(1) the nature of the change;

(2) how the change affects the delivery of or access to covered services; and

(3) the [~~MCO/SE's~~] MCO's/SE's plan for maintaining access and the quality of member care.

D. **Required policies and procedures:** The MCO/SE shall maintain policies and procedures on provider recruitment and termination of provider participa-

tion with the MCO/SE. The recruitment policies and procedures shall describe how an MCO/SE responds to a change in the network that affects access and its ability to deliver services in a timely manner. The MCO/SE:

(1) must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;

(2) must not discriminate against providers with respect to participation, reimbursement, or indemnification for any provider acting within the scope of that provider's license or certification under applicable state law solely on the basis of the provider's license or certification;

(3) must not decline to include individual or groups of providers in its network without giving the affected providers written notice of the reason for its decision;

(4) shall not be required to contract with providers beyond the number necessary to meet the needs of its members;

(5) shall be allowed to use different reimbursement amounts for different specialties or for different practitioners within the same specialty;

(6) shall be allowed to establish measures that are designed to maintain quality of services and control costs and are consistent with its responsibility to members;

(7) may not employ or contract with providers or entities excluded from participation in federal health care programs because of misconduct; and

(8) shall not be required to contract with providers who are ineligible to receive reimbursement under medicaid fee-for-service.

E. **General information submitted to HSD:** The MCO shall maintain an accurate unduplicated list of contracted, subcontracted and terminated PCPs, specialists, hospitals and other providers participating or affiliated with the MCO. The SE shall maintain an accurate unduplicated list of contracted, subcontracted, and terminated behavioral health providers for both mental health and substance abuse. The MCO/SE shall submit a list to HSD on a regular basis, as determined by HSD, and include a clear delineation of all additions and terminations that have occurred since the last submission.

[8.305.6.9 NMAC - Rp 8 NMAC 4.MAD.606.5.1, 7-1-01; A, 7-1-03; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.6.12 PRIMARY CARE PROVIDERS: The primary care provider (PCP) must be a participating MCO medical provider who has the responsibility for supervising, coordinating and providing primary health care to members, initiating referrals for specialist care and maintaining the continuity of the member's care. The MCO shall distribute information to the providers explaining the medicaid-specific policies and procedures outlining PCP responsibilities.

A. **Primary care responsibilities:** The MCO shall develop policies and procedures to ensure that the following primary care responsibilities are met by the PCP or in another manner:

(1) 24-hour, seven day a week access to care;

(2) coordination and continuity of care with providers who participate within the MCO network and with providers outside the MCO network according to MCO policy;

(3) maintenance of a current medical record for the member, including documentation of services provided to the member by the PCP and specialty or referral services;

(4) ensuring the provision of services under the EPSDT program based on the periodicity schedule for members under age 21;

(5) requiring PCPs contracted with the MCO to vaccinate members in their offices and not refer members elsewhere for immunizations; the MCO shall encourage its PCPs to participate in the vaccines for children program administered by the department of health (DOH);

(6) ensuring the member receives appropriate prevention services for his age group;

(7) ensuring that care is coordinated with other types of health and social program providers, including but not limited to behavioral health, including mental health and substance abuse, the women, infants and children program (WIC), children, youth, and families department (CYFD), adult and child protective services and juvenile justice division;

(8) governing how coordination with the PCP will occur with hospitals that require in-house staff to examine or treat members having outpatient or ambulatory surgical procedures performed; and

(9) governing how coordination with the PCP and hospitalists will occur when an individual with a special health care need is hospitalized.

B. **Types of primary care providers:** The MCO may designate the following providers as PCPs, as appropriate:

(1) medical doctors or doctors of osteopathic medicine with the following specialties: general practice, family practice, internal medicine, gerontology, obstetrics, gynecology and pediatrics;

(2) certified nurse practitioners, certified nurse midwives and physician assistants;

(3) specialists, on an individualized basis for members whose care is more appropriately managed by a specialist, such as members with infectious diseases, chronic illness or a disability;

(4) primary care teams consisting of residents and a supervising faculty physician for contracts with teaching facilities or teams that include certified mid-level practitioners who, at the member's request, may serve as the point of first contact; in both instances, the MCO shall organize its teams to ensure continuity of care to members and shall identify a "lead physician" within the team for each member; the "lead physician" shall be an attending physician (medical students, interns and residents cannot serve as the "lead physician"); or

(5) other providers who meet the MCO credentialing requirements as a PCP.

C. **Providers that shall not be excluded as PCPs:** MCOs shall not exclude providers as primary care providers based on the proportion of high-risk patients in their caseloads.

D. **Selection or assignment to a PCP:** The MCO shall maintain written policies and procedures governing the process of member selection of a PCP and requests for a change in PCP.

(1) **Initial enrollment:** At the time of enrollment into the MCO, the MCO shall ensure that each member may choose a PCP within a reasonable distance from the member's residence.

(a) The MCO shall assume responsibility for assisting members with

PCP selection.

(b) The process whereby the MCO assigns members to PCPs shall include at least the following features:

(i) the MCO shall contact the member within five business days of enrollment and provide information on options for selecting a PCP;

(ii) the MCO must offer freedom of choice to members in making a selection;

(iii) a member shall choose a PCP or the MCO will assign a PCP within 15 calendar days of enrollment with the MCO; a member may select a PCP from the information provided by the MCO; a member may choose a PCP anytime during this selection period;

(iv) the MCO shall notify the member in writing of his PCP's name, location and office telephone number; and

(v) the MCO shall provide the member with an opportunity to select a different PCP if he is dissatisfied with the assigned PCP.

(2) **Subsequent change in PCP initiated by member:** Members may initiate a PCP change at any time, for any reason. The request for PCP change may be made in writing or by telephone. If the change is requested by the 20th day of the month it will become effective the first day of the following month. If the request is made after the 20th day it will become effective the first day of the second month following the request. A PCP change may also be initiated on behalf of a member by the member's parents or legal guardians of a minor or incapacitated adult.

(3) **Subsequent change in PCP initiated by the MCO:** In instances where a PCP has been terminated or suspended for potential quality or fraud and abuse issues, the MCO shall allow affected members to select another PCP or make an assignment within 15 calendar days of the termination effective date. The MCO shall notify the member in writing of the PCP's name, location and office telephone number. The MCO may initiate a PCP change for a member under certain circumstances such as:

(a) the member and MCO agree that assignment to a different PCP in the MCO is in the member's best interest, based on the member's medical condition;

(b) a member's PCP ceases to participate in the MCO's network;

(c) a member's behavior toward the PCP is such that it is not feasible to safely or prudently provide medical care and the PCP has made all reasonable efforts to accommodate the member; or

(d) a member has initiated legal action against the PCP.

(4) **Provider lock-in:** HSD shall allow the MCO to require that a member see a certain provider while ensuring reasonable access to quality services when identification of utilization of unnecessary services or a member's behavior is detrimental or indicates a need to provide case continuity. Prior to placing a member on provider lock-in, the MCO shall inform the member of the intent to lock-in, including the reasons for imposing the provider lock-in and that the restriction does not apply to emergency services furnished to the member. The MCO's grievance procedure shall be made available to a member disagreeing with the provider lock-in. The member shall be removed from provider lock-in when the MCO has determined that the utilization problems or detrimental behavior have ceased and that recurrence of the problems is judged to be improbable. HSD shall be notified of provider lock-ins on a quarterly basis and informed of provider lock-in removals at the time they occur.

(5) **Pharmacy lock-in:** HSD shall allow the MCO/SE to require that a member see a certain pharmacy provider when member compliance or drug seeking behavior is suspected. Prior to placing the member on pharmacy lock-in, the MCO/SE shall inform the member or his/her representative of the intent to lock-in. The MCO's/SE's grievance procedure shall be made available to the member being designated for pharmacy lock-in. The pharmacy lock-in shall be reviewed and documented by the MCO/SE and reported to HSD every quarter. The member shall be removed from pharmacy lock-in when the MCO/SE has determined that the compliance or drug seeking behavior has been resolved and the recurrence of the problem is judged to be improbable. HSD shall be notified of all lock-in removals.

E. **MCO responsibility for PCP services:** The MCO shall be responsible for monitoring PCP actions to ensure compliance with MCO and HSD policies. The MCO shall communicate with and educate PCPs about special populations and their service needs. The MCO shall ensure that PCPs are successfully identifying and referring members to specialty providers as medically necessary.

[8.305.6.12 NMAC - Rp 8 NMAC 4.MAD.606.5.4, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-09]

8.305.6.18 MCO/SE PROVIDER TRANSITION OF CARE: The [~~MCO~~] MCO/SE shall notify HSD [~~and the SE shall notify the collaborative~~] of unexpected changes to the composition of its provider network that would have a significantly negative effect on member access to services or on the [~~MCO/SE's~~] MCO's/SE's ability to deliver services included in the benefit package in a timely manner. In the event that provider network changes are unexpected or when it is determined that a provider is unable to meet their contractual obligation, the [~~MCO~~] MCO/SE shall be required to submit a transition plan(s) to HSD for all affected members [~~and the SE shall be required to submit transition plans to the collaborative for all affected consumers~~].

[8.305.6.18 NMAC - N, 7-1-07; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.7 NMAC, Sections 8 and 11, which will be effective July 1, 2009.

8.305.7.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost-effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.

[8.305.7.8 NMAC - Rp 8.305.7.8 NMAC, 7-1-04; A, 7-1-09]

8.305.7.11 SERVICES INCLUDED IN THE MEDICAID BENEFIT PACKAGE:

A. **Inpatient hospital services (MCO/SE):** The benefit package includes hospital inpatient acute care, procedures and services for members, as detailed in 8.311.2 NMAC, *Hospital Services*. The MCO shall comply with the maternity length of stay in the Health Insurance Portability and Accountability Act of 1996. Coverage for a hospital stay following a normal, vaginal delivery may not be limited to less than 48 hours for both the mother and the newborn child. Health coverage for a hospital stay in connection with childbirth following a caesarian section may not be limited to less than 96 hours for mother and newborn child.

B. **Transplant services (MCO only):** The following transplants are covered in the benefit package as long as the indications are not considered experimental or investigational: heart transplants, lung transplants, heart-lung transplants, liver transplants, kidney transplants, autologous bone marrow transplants, allogeneic bone marrow transplants and corneal transplants, as detailed in 8.325.5 NMAC, *Transplant Services*. Also see 8.325.6 NMAC, *Experimental or Investigational Procedures, Technologies or Non-Drug Therapies* for guidance on determining if transplants are experimental or investiga-

tional.

C. **Hospital outpatient service (MCO/SE):** The benefit package includes hospital outpatient services for preventive, diagnostic, therapeutic, rehabilitative or palliative medical or behavioral health services as detailed in 8.311.2 NMAC, *Outpatient Covered Services.*

D. **Case management services (MCO):** The benefit package includes case management services necessary to meet an identified service need as detailed in 8.326.2 NMAC through 8.326.6 NMAC and 8.320.5 NMAC [MAD 771 through MAD 775 and MAD 744].

E. **Specific case management programs:** The following are specific case management programs available to medicaid members within the MCO, which meet the requirements specified in policy manual parts:

(1) **case management services for adults with developmental disabilities (MCO only):** Case management services provided to adult members (21 years of age or older) who are developmentally disabled, as detailed in 8.326.2 NMAC [MAD 771], *Case Management Services for Adults with Developmental Disabilities*;

(2) **case management services for pregnant women and their infants (MCO only):** Case management services provided to pregnant women up to 60 days following the end of the month of the delivery, as detailed in 8.326.3 NMAC [MAD 772], *Case Management Services for Pregnant Women and Their Infants*;

(3) **case management services for traumatically brain injured adults (MCO only):** Case management services provided to adults who are 21 years of age or older who are traumatically brain injured, as detailed in 8.326.5 NMAC [MAD 774], *Case Managed Services for Traumatically Brain Injured Adults*;

(4) **case management services for children up to the age of three (MCO only):** Case management services for children up to the age of three who are medically at risk due to family conditions and not developmentally delayed, as detailed in 8.326.6 NMAC [MAD 775], *Case Management Services for Children Up to Age Three*; and

(5) **case management services for the medically at risk (MCO only):** Case management services for individuals who are under 21 who are medically at risk for physical or behavioral health conditions, as detailed in 8.320.5 NMAC [MAD 744], *EPSDT Case Management*; the benefit package does not include case management provided to developmentally disabled children ages 0-3 who are receiving early intervention services, or case management services provided by the children, youth and families department and defined as protective services case management or juvenile probation and parole officer case management; "medically at risk" is defined as those individuals who have a diagnosed physical or behavioral health condition which has a high probability of impairing their cognitive, emotional, neurological, social, behavioral or physical development.

F. **Emergency services (MCO/SE):** The benefit package includes inpatient and outpatient services meeting the definition of emergency services. It is the responsibility of the MCOs to cover emergency room facility costs even when the primary diagnosis is a behavioral health diagnosis, with the exception of UNM psychiatric emergency room, which will be the responsibility of the SE. Services shall be available 24 hours per day and 7 days per week. Services meeting the definition of emergency services shall be provided without regard to prior authorization or the provider's contractual relationship with the MCO/SE. If the services are needed immediately and the time necessary to transport the member to a network provider would mean risk of permanent damage to the member's health, emergency services shall be available through a facility or provider participating in the MCO/SE network or from a facility or provider not participating in the MCO/SE network. Either provider type shall be paid for the provision of services on a timely basis. Emergency services include services needed to evaluate and stabilize an emergency medical or behavioral condition. Post stabilization care services means covered services, related to an emergency medical or behavioral condition, that are provided after a member is stabilized in order to maintain this stabilized condition. This coverage may include improving or resolving the member's condition if either the MCO/SE has authorized post-stabilization services in the facility in question, or there has been no authorization; and

(1) the hospital was unable to contact the MCO/SE; or

(2) the hospital contacted the MCO/SE but did not get instructions within an hour of the request.

G. **Physical health services (MCO only):** The benefit package includes primary (including those provided in school-based settings) and specialty physical health services provided by a licensed practitioner performed within the scope of practice, as defined by state law and detailed in 8.310.2 NMAC, *Medical Services Providers*; 8.310.10 NMAC, *Midwife Services*, including out of hospital births and other related birthing services performed by certified nurse midwives or direct-entry midwives licensed by the state of New Mexico, who are either validly contracted with and fully credentialed by the MCO or validly contracted with HSD and participate in HSD's birthing options program; 8.310.11 NMAC, *Podiatry Services*; 8.310.3 NMAC, *Rural Health Clinic Services*; and 8.310.4 NMAC [MAD 713], *Federally Qualified Health Center Services*.

H. **Laboratory services (MCO or SE):** The benefit package includes laboratory services provided according to the applicable provisions of Clinical Laboratory Improvement Act (CLIA), as detailed in 8.324.2 NMAC, *Laboratory Services*. Laboratory costs shall be the responsibility of the SE when they are provided within, and billed by, a freestanding psychiatric hospital, a PPS exempt unit of a general acute hospital or UNM psychiatric emergency room. In the event that a psychiatrist orders lab work but completes that lab work in his/her office/facility and bills for it, the SE shall be responsible for payment. Lab costs shall be the responsibility of the MCO when a BH provider orders lab work that is performed by an outside, independent laboratory, including those lab services provided for persons within a freestanding psychiatric hospital, a psychiatric unit, a psychiatric unit within a general hospital or UNM psychiatric ER. All other covered laboratory services shall be the responsibility of the MCO.

I. **Diagnostic imaging and therapeutic radiology services (MCO or SE):** The benefit package includes medically necessary diagnostic imaging and radiology services, as detailed in 8.324.3 NMAC, *Diagnostic Imaging and Therapeutic Radiology Services*. Radiology costs shall be the responsibility of the SE when they are provided within, and billed by, a freestanding psychiatric hospital, a PPS exempt unit of a general acute hospital or UNM psychiatric emergency room. In the event that a psychiatrist orders radiology services but completes those tests in his/her office/facility and bills for it, the SE shall be responsible for payment. Radiology costs shall be the responsibility

of the MCO when a BH provider orders radiology services that are performed by an outside, independent radiology facility, including those radiology services provided for persons within a freestanding psychiatric hospital, a psychiatric unit, a psychiatric unit within a general hospital or UNM psychiatric ER. All other diagnostic imaging and therapeutic radiology services shall be the responsibility of the MCO.

J. **Anesthesia services (MCO):** The benefit package includes anesthesia and monitoring services necessary for the performance of surgical or diagnostic procedures, as detailed in 8.310.5 NMAC, *Anesthesia Services*. Reimbursement for anesthesia related to electroconvulsive therapy (ECT) shall be the responsibility of the MCO.

K. **Vision services (MCO only):** The benefit package includes vision services, as detailed in 8.310.6 NMAC, *Vision Care Services*.

L. **Audiology services (MCO only):** The benefit package includes audiology services, as detailed in 8.324.6 NMAC, *Hearing Aids and Related Evaluation*.

M. **Dental services (MCO only):** The benefit package includes dental services, as detailed in 8.310.7 NMAC, *Dental Services*.

N. **Dialysis services (MCO only):** The benefit package includes medically necessary dialysis services, as detailed in 8.325.2 NMAC, *Dialysis Services*. Dialysis providers shall assist members in applying for and pursuing final medicare eligibility determination.

O. **Pharmacy services (MCO/SE):** The benefit package includes all pharmacy and related services, as detailed in 8.324.4 NMAC, *Pharmacy Services*. The MCO/SE shall maintain written policies and procedures governing its drug utilization review (DUR) program in compliance with all applicable federal medicaid laws. The MCO/SE shall use a single medicaid preferred drug list (PDL). The MCO/SE shall cover brand name drugs and drug items not generally on the MCO/SE formulary or PDL when determined to be medically necessary by the MCO/SE or through a fair hearing process. The MCO/SE shall include on their formulary or PDL all multi-source generic drug items with the exception of items used for cosmetic purposes, items consisting of more than one [~~(1)~~] therapeutic ingredient, anti-obesity items, items which are not medically necessary, and cough, cold and allergy medications. The MCO/SE shall reimburse family planning clinics, school-based health clinics, and DOH public health clinics for oral contraceptive agents and Plan B when dispensed to members and billed using HCPC codes and CMS 1500 claim forms. The MCO shall coordinate as necessary with the SE, and the SE shall coordinate with the MCO and the member's PCP when administering pharmacy services. The SE shall be responsible for payment of all drug items prescribed by a behavioral health provider, such as psychiatrists, psychologists certified to prescribe, psychiatric clinical nurse specialists, psychiatric nurse practitioners, and any other prescribing practitioner contracted with the SE. The MCO/SE shall ensure that Native American members accessing the pharmacy benefit at IHS or tribal 638 facilities will be exempt for the MCO's/SE's preferred drug list.

P. **Durable medical equipment and medical supplies (MCO only):** The benefit package includes the purchase, delivery, maintenance and repair of equipment, oxygen and oxygen administration equipment, nutritional products, disposable diapers, augmentative alternative communication devices and disposable supplies essential for the use of the equipment, as detailed in 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies*.

Q. **EPSDT services (MCO/SE):** The benefit package includes the delivery of the federally mandated early and periodic screening, diagnostic and treatment (EPSDT) services provided by a PCP and physical or behavioral health specialist, as detailed in 8.320.2 NMAC, *EPSDT Services*. The SE shall provide access to early intervention programs/services for members identified in an EPSDT screen as being at risk for developing or having a severe emotional, behavioral or neurobiological disorder.

R. **Tot-to-teen health checks (MCO only):** The MCO shall adhere to the periodicity schedule and ensure that eligible members receive EPSDT screens (tot-to-teen health checks). The services include the following with respect to treatment follow-up:

(1) education of and outreach to members regarding the importance of the health checks;

(2) development of a proactive approach to ensure that the members receive the services;

(3) facilitation of appropriate coordination with school-based providers;

(4) development of a systematic communication process with MCO network providers regarding screens and treatment coordination;

(5) processes to document, measure and assure compliance with the periodicity schedule; and

(6) development of a proactive process to insure the appropriate follow-up evaluation, referral and treatment, including early intervention for vision and hearing screening, dental examinations and current immunizations; the MCO will facilitate referral to the SE for identified behavioral health conditions.

S. **EPSDT private duty nursing (MCO only):** The benefit package includes private duty nursing for the EPSDT population, as detailed in 8.323.4 NMAC, *EPSDT Private Duty Nursing Services*. The services shall either be delivered in the member's home or the school setting.

T. **EPSDT personal care (MCO only):** The benefit package includes personal care services for the EPSDT population, as detailed in 8.323.2 NMAC, *EPSDT Personal Care Services*.

U. **Services provided in schools (MCO/SE):** The benefit package includes services provided in schools, excluding those specified in the individual education plan (IEP) or the individualized family service plan (IFSP), as detailed in 8.320.6 NMAC, *School-Based Services for Recipients under 21 Years Of Age*.

V. **Nutritional services (MCO only):** The benefit package includes nutritional services furnished to pregnant women and children as detailed in 8.324.9 NMAC, *Nutrition Services*.

W. **Home health services (MCO only):** The benefit package includes home health services, as detailed in 8.325.9 NMAC, *Home Health Services*. The MCO is required to coordinate home health and the home and community-based waiver programs if a member is eligible for both home health and waiver services.

X. **Hospice services (MCO only):** The benefit package includes hospice services, as detailed in 8.325.4 NMAC, *Hospice Care Services*.

Y. **Ambulatory surgical services (MCO only):** The benefit package includes surgical services rendered in an ambulatory surgical center setting, as detailed in 8.324.10 NMAC, *Ambulatory Surgical Center Services*.

Z. **Rehabilitation services (MCO only):** The benefit package includes inpatient and outpatient hospital and outpatient physical, occupational and speech therapy services, as detailed in 8.325.8 NMAC, *Rehabilitation Services Providers* and licensed speech and language pathology services furnished under the EPSDT program as detailed in 8.323.5 NMAC, *Licensed Speech and Language Pathologists*. The MCO is required to coordinate rehabilitation services with the home and community-based waiver programs if a member is eligible for rehabilitation and waiver services.

AA. **Reproductive health services (MCO only):** The benefit package includes reproductive health services, as

detailed in 8.325.3 NMAC, *Reproductive Health Services*. The MCO will provide female members with direct access to women's health specialists within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.

(1) The MCO shall provide medicaid members with sufficient information to allow them to make informed choices including the following:

(a) types of family planning services available;

(b) a member's right to access these services in a timely and confidential manner; and

(c) freedom to choose a qualified family planning provider who participates in the MCO network or from a provider who does not participate in the MCO network.

(2) If members choose to receive family planning services from an out-of-network provider, they shall be encouraged to exchange medical information between the PCP and the out-of-network provider for better coordination of care.

BB. **Pregnancy termination procedures (MCO only):** The benefit package includes services for the termination of pregnancy as allowed by 42 CFR 441.200 et seq. Medically necessary pregnancy terminations which do not meet the requirements of 42 CFR 441.202 are excluded from the capitation payment made to the MCO and shall be reimbursed solely from state funds pursuant to the provisions of 8.325.7 NMAC, *Pregnancy Termination Procedures*.

CC. **Emergency and non-emergency transportation services (MCO only):** The benefit package includes transportation service such as ground ambulance, air ambulance, taxicab and handivan, commercial bus, commercial air, meal and lodging services as indicated for medically necessary physical and behavioral health services, as detailed in 8.324.7 NMAC, *Transportation Services*. Non-emergency transportation is covered only when a member does not have a source of transportation available and when the member does not have access to alternative free sources. The MCO/SE shall coordinate efforts when providing transportation services for medicaid members/customers requiring physical or behavioral health services.

DD. **Prosthetics and orthotics (MCO only):** The benefit package includes prosthetic and orthotic services as detailed in 8.324.8 NMAC, *Prosthetics and Orthotics*.

EE. **Preventative physical health services (MCO only):** The benefit package shall include preventative services that follow current national standards and are recommended by the U.S preventive services task force, the centers for disease control and prevention, or the American college of obstetricians and gynecologists. The MCO shall follow current national standards for preventive health services.

FF. **Telehealth services (MCO/SE):** The benefit package includes telehealth services as detailed in 8.310.13 NMAC, *Telehealth Services.*

[8.305.7.11 NMAC - Rp 8.305.7.11 NMAC, 7-1-04; A, 7-1-05; A, 9-1-06; A, 7-1-07; A, 7-1-08; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.8 NMAC, Sections 8, 9 and 11 – 19, which will be effective July 1, 2009.

8.305.8.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost-effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.

[8.305.8.8 NMAC - N, 7-1-01, A, 7-1-09]

8.305.8.9 QUALITY MANAGEMENT: [~~HSD recognizes that strong programs of quality improvement and assurance help ensure that better care is delivered in a cost effective manner to the member. Under the terms of the medicaid managed care contracts, quality management programs are incorporated into health care delivery and administrative systems.~~] Quality management is both a philosophy and a method of management designed to improve the quality of services; includes both quality assurance and quality improvement activities; and, is incorporated into health care delivery and administrative systems.

[8.305.8.9 NMAC - Rp 8 NMAC 4.MAD.606.7, 7-1-01; A, 7-1-04; A, 7-1-09]

8.305.8.11 BROAD STANDARDS:

A. **NCQA requirement:** The MCO shall have and maintain national committee for quality assurance (NCQA) accreditation for its medicaid product line. If the MCO is not so accredited, it will actively pursue such accreditation. NCQA accreditation is not required for the SE.

(1) [~~An MCO with NCQA national accreditation shall provide HSD a copy of its current certificate of accreditation together with a copy of the survey report, scores for the medicaid product line using the standards categories and scores using the reporting categories. In addition, the MCO shall provide to HSD a copy of any annual NCQA or national accreditation review/revision of accreditation status for the medicaid product line.~~] An MCO with NCQA national accreditation shall provide HSD with a copy of its current certificate of accreditation, a copy of any accreditation review/revision of accreditation status and a copy of the NCQA survey report for the medicaid product line.

(2) [~~If the MCO is not accredited, it~~] A non-accredited MCO must provide a copy of the NCQA/national accreditation confirmation letter indicating the date for the site visit.

B. **HEDIS requirement:** The MCO shall submit a copy of its audited [~~health plan employer~~] healthcare effectiveness data and information set (HEDIS) data submission tool [~~to HSD~~] and the results of the MCO's HEDIS Compliance Audit™ to HSD or its designee at the same time it is submitted to NCQA. The MCO is expected to use and rely upon HEDIS data as an important measure of performance for HSD. The MCO is expected to use HEDIS data as a measure of performance and to incorporate the results of each year's HEDIS data submission into its QI/QM plan. [~~For the MCO accredited by NCQA, the data submission shall be at the same time it is submitted to NCQA. The results of the MCO's HEDIS ® Compliance Audit ™ shall accompany its data submission tool.~~]

C. **Mental health reporting requirement:** The SE shall [~~be responsible for the collection and submission of~~] collect and submit a statistically valid New Mexico consumer/family satisfaction project (C/FSP) survey [~~for both~~] to include the medicaid adult and child family population [~~as an annual reporting requirement. The SE shall adhere to the established HSD survey administration and reporting process. The annual C/FSP shall also~~] annually. The annual C/FSP survey shall be conducted on a calendar year basis and shall include non-survey indicators defined by HSD [~~as part of this reporting requirement for~~] each contract calendar year. [~~The SE shall report the C/FSP data set and any additional HSD requested data that are similar to that of C/FSP to HSD annually each fiscal year.~~] The SE shall submit to HSD a written analysis of the annual C/FSP report for medicaid based on the aggregate survey data results for both the child/family and adult medicaid populations.

D. **Collection of clinical data:** [~~For indicators requiring clinical data~~

~~as a data source, the MCO/SE shall collect and utilize a sample of clinical records sufficient to produce statistically valid results. The size of the sample shall support stratification of the population by a range of demographic and clinical factors pertinent to the special vulnerable populations served. These populations shall include, but are not limited to, ethnic minorities, homeless, pregnant women, gender and age based populations~~] The MCO shall collect clinical data utilizing a sample of clinical records sufficient to produce statistically valid results. The sample shall support stratification of the population served.

E. **Behavioral health data (SE only):** [~~For reporting purposes, BH data shall be collected and reported for any medicaid managed care member receiving any behavioral health service provided by a licensed or certified behavioral health practitioner, regardless of setting or location as required by HSD. This includes behavioral health licensed professionals, practicing within the SE. The SE shall monitor and ensure the integrity of data. Findings shall be reported to HSD upon request.~~] For reporting purposes, BH data for medicaid managed care members shall include all behavioral health services regardless of setting or location. Data shall be collected and reported as required to HSD.

F. **Provision of emergency services:** The MCO shall ensure that acute general hospitals are reimbursed for emergency services [~~which they will provide because of federal mandate,~~] provided in compliance of federal mandates, such as the "anti-dumping" law in the Omnibus Reconciliation Act of 1989, P.L. (101-239) and 42 U.S.C. Section 1395dd. (1867 of the Social Security Act). The SE shall ensure that the UNM psychiatric emergency room is reimbursed for emergency services provided.

G. **Disease reporting:** The MCO/SE shall require its providers to comply with the disease reporting required by the "New Mexico Regulations Governing the Control of Disease and Conditions of Public Health Significance, 1980".

H. **Other required reporting:** The MCO/SE agrees to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. Section 7401 et seq. and the Federal Water Pollution Control Act, as amended and codified at 33 U.S.C. Section 1251 et seq. [~~In addition to any and all remedies or penalties set forth in this agreement, any~~] Any violation of this provision shall be reported to the HHS and the appropriate regional office of the environmental protection agency.

[8.305.8.11 NMAC - Rp 8 NMAC 4.MAD.606.7.2, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-08; A, 7-1-09]

8.305.8.12 STANDARDS FOR QUALITY MANAGEMENT AND IMPROVEMENT:

A. **Program structure:** [~~Quality management is an integrated approach that links knowledge, structure and processes together throughout an MCO/SE's system to assess and improve quality. The goal of quality improvement activities is to improve the quality of clinical care and services provided to members in the areas of health care delivery as well as supportive administrative systems.~~] The MCO/SE's quality management (QM) and improvement (QI) structures and processes shall be planned, systematic, clearly defined, and at least as stringent as federal requirements; responsibilities shall be assigned to appropriate individuals. [~~The MCO/SE shall submit annually its comprehensive QM/QI plan for the coming year as well as a comprehensive QM/QI evaluation of the previous year's achievement and performance of its QM/QI goals and initiatives. The QI program for the MCO/SE shall be reviewed and approved by HSD annually.~~] Internal processes shall be transparent and accountable. The MCO/SE's [~~QI/QM~~] QM/QI activities shall demonstrate the linkage of quality improvement projects to findings from multiple quality evaluations, such as the external quality review (EQR) annual evaluation, [~~opportunities for improvement identified from either the~~] annual HEDIS indicators, [~~or~~] state defined performance measures and [~~the annually required~~] consumer satisfaction surveys and provider surveys [~~as well as any findings identified by an accreditation body such as NCQA~~].

(1) The [~~QI~~] QM/QI program shall include: specific [~~QI~~] targeted goals, objectives and structure that cover the MCO/SE's immediate objectives for each contract year or calendar year, and long-term objectives for the entire contract period. The annual [~~QI~~] plan shall include the specific interventions to be utilized to improve the quality targets, as well as, the timeframes for evaluation.

[~~(2) The QI program shall be accountable to the governing body that reviews and approves the QI program.~~

~~(3) The program description shall specify the roles, authority and responsibilities of a designated physician/psychiatrist in the QI program.~~

~~(4) A quality related committee shall oversee and be involved in QI activities.~~

~~(5) The program description shall specify the role of the QI committee and subcommittees, including any committees dealing with oversight of delegated activities.~~

~~(6) The program description shall describe QI committee composition, including MCO/SE providers, committee member selection policies, roles and responsibilities.~~

~~(7) The program description shall include: the QI committee functions, including policy recommendations; review/evaluation of quality improvement activities; institution of needed actions; follow up of instituted actions; and contemporaneous documentation of committee decisions and actions.~~]

(2) Internal processes shall be transparent and accountable; processes shall reflect policies and procedures and activities shall be documented.

[~~(8)~~] (3) The program description shall address [~~QI~~] QM/QI for all major demographic groups within the MCO/SE. [~~, such as, infants, children, adolescents, adults, seniors and special population groups, including, but not limited to, specific racial and ethnic groups, pregnant members, developmentally disabled members and persons with behavioral health disorders (SE only), including co-occurring disorders, or other chronic diseases.~~

~~(9) The program description shall address member satisfaction, including methods of collecting and evaluating information, including the consumer assessment of health plans survey (CAHPS), a survey identifying opportunities for improvement, implementing and measuring effectiveness of intervention and informing providers of results.~~

~~(10)~~] (4) The QM/QI description or work plan shall address the process by which the MCO/SE adopts reviews, [~~at least every two years and appropriately~~] updates and disseminates evidence-based clinical practice guidelines for provision of services for acute and chronic conditions, including behavioral health (SE only). The MCO/SE shall involve its providers in this process.

[~~(11) The program description or work plan shall address activities aimed at addressing culture specific health beliefs and behaviors as well as risk conditions and shall respond to member and provider requests for culturally appropriate services. Culturally appropriate services may include: language and translation services, dietary practices, individual and family interaction norms and the role of the family in compliance with long-term treatment. The MCO/SE shall incorporate cultural competence into utilization management, quality improvement, and the planning for the course of treatment.~~

~~(12)~~] (5) The program description or work plan shall address activities to improve health status of members with chronic conditions, including identification

of such members; implementation of services and programs to assist such members in managing their conditions, including behavioral health; and informing providers about the programs and services for members assigned to them.

[~~(13) The program description or work plan shall address activities that ensure continuity and coordination of care, including physical and behavioral health services, collection and analysis of data, and appropriate interventions to improve coordination and continuity of care~~.

~~(14) The program description or work plan shall include specific activities that facilitate continuity and coordination of physical and behavioral health care. The responsibility for these activities shall not be delegated.~~

~~(15) The program description shall include: objectives for the year; activities regarding quality of clinical care and service, timelines, responsible person, planned monitoring for both newly identified and previously identified issues and an annual evaluation of the QI program.~~

~~(16) The program description shall include means by which the MCO/SE shall, upon request, communicate quality improvement results to its members and providers.~~

~~(17) The QI program personnel and information resources shall be adequate to meet program needs and devoted to and available for quality improvement activities~~.

~~(18)~~] (6) The annual written evaluation [~~submitted to HSD~~] shall include a review of completed and continuing quality improvement activities that address quality of clinical care and quality of service; determination and documentation of any demonstrated improvements in quality of care and service. [~~; and evaluation of the overall effectiveness of the QI program based on evidence of meaningful improvements (See Subsection J of 8.305.8.12 NMAC, *Effectiveness of the QI Program*)~~

~~(19) For targeting QI activities to the provider and consumer surveys, the program description or work plan shall include specific activities related to findings identified in the annual consumer and provider surveys as areas that indicate targeted QI interventions and monitoring.~~]

B. **Program operations:** The [~~QI~~] QM/QI committee shall:

(1) [~~recommend QI policy~~] review and evaluate the results of quality improvement activities, institute needed action and ensure follow-up, as appropriate;

(2) have contemporaneous dated and signed minutes that reflect all [~~QI~~] QM/QI committee decisions and actions;

[~~(3) ensure that the MCO/SE's providers participate actively in the QI program;~~

~~(4)~~] (3) ensure that the MCO/SE shall coordinate the [~~QI~~] QM/QI program with performance monitoring activities throughout the organization, including but not limited to, utilization management, fraud and abuse detection, credentialing, monitoring and resolution of member grievances and appeals, assessment of member satisfaction and medical records review; and

[~~(5)~~] (4) ensure that [~~there shall be evidence that~~] the results of [~~QI~~] QM/QI activities, performance improvement projects and reviews are used to improve quality [~~there will be evidence of communication of and use of the results of QI activities, performance improvement projects and reviews, with appropriate individual and institutional providers;~~

~~(6) ensure that the MCO/SE shall also coordinate the QI program with performance monitoring activities throughout the organization, including but not limited to, its compliance with all quality standards and other specifications in the contract for medicaid services, such as compliance with state standards;~~

~~(7) ensure that the MCO/SE QI program is applied to the entire range of health services provided through the MCO/SE by assuring that all major population groups, care settings and types of service are included in the scope of the review; a major population or prevalent group is one that represents at least 5% of an MCO/SE's enrollment; and~~

~~(8) ensure that stakeholders/members have an opportunity to provide input~~].

C. **Health services contracting:** Contracts with individual and institutional providers shall specify [~~that contractors cooperate~~] compliance with the MCO/SE's [~~QI~~] QM/QI program.

D. **Continuous quality improvement/total quality management:** The MCO/SE shall ensure that both clinical and nonclinical aspects of the MCO/SE quality management program shall be based on principles of continuous quality improvement/total quality management (CQI/TQM). Such an approach shall include at least the following:

(1) recognition that opportunities for improvement are unlimited;

(2) be data driven;

(3) use real-time member and provider input to develop CQI activities; and

(4) require on-going measurement of clinical and non-clinical effectiveness and programmatic improvements.

E. **Member satisfaction:** The MCO/SE shall [~~implement methods aimed at member satisfaction with the active involvement and participation of members and their families, whenever possible~~] ensure results of member satisfaction surveys are used to improve quality.

[~~(1) The MCO in accordance with NCQA requirements, shall conduct and submit to HSD as part of its HEDIS reporting requirements, an annual survey of member satisfaction (CAHPS or latest version of adult and child instruments). The SE, in accordance with the requirement for the annual consumer satisfaction survey, will submit the C/FSP analysis report to HSD and utilize its results in the following year's quality initiatives.~~

~~(2)~~] (1) The MCO/SE shall evaluate member grievances and appeals for trends and specific problems [~~, including behavioral health problems~~].

~~(3)~~] (2) The MCO/SE shall use input from the consumer advisory board to identify opportunities for improvement. [~~in the quality of MCO/SE performance.~~

~~(4)~~] (3) The MCO/SE shall implement interventions [~~to improve its performance~~] and measure the effectiveness of these interventions.

[~~(5) The MCO/SE shall measure the effectiveness of the interventions.~~

~~(6)~~] (4) The MCO/SE shall inform members, providers [~~,~~] and HSD [~~, and the MCO/SE members~~] of the results of member satisfaction activities as specified by HSD.

[~~(7) The MCO shall participate in the design of specific questions for the CAHPS adult and child surveys.~~]

F. **Health management systems:**

(1) The MCO/SE shall actively work to improve the health status of its members with chronic physical and behavioral health conditions, utilizing best practices throughout the MCO/SE's provider networks. [~~Additionally, the MCO/SE shall implement policies and procedures for coordinating care between their organizations.~~]

(a) The MCO shall proactively identify members with chronic medical conditions, and offer appropriate outreach, services and programs to assist in managing and improving their chronic conditions. The SE shall proactively identify members with chronic behavioral health [~~(both mental health and substance abuse) conditions, including co-occurring disorders,~~] conditions and offer appropriate outreach, services and programs to assist in managing and improving their chronic behavioral health [~~conditions~~] patient outcomes.

[~~(b) The SE shall proactively identify the unduplicated number of adult severely disabled mentally ill (SDMI) and severe emotionally, behaviorally and neurobiologically disturbed children (SED); and chronic substance abuse (CSA) members served, including those with co-occurring mental health and substance abuse disorders.~~

~~(c) The MCO/SE shall report the following adverse events involving SDMI, SED, CSA, and co-occurring mental health and substance abuse members to HSD on a monthly basis: suicides, other deaths, attempted suicides, involuntary hospitalizations, detentions for protective custody and detentions for alleged criminal activity utilizing and HSD provided reporting template. The SE shall utilize HSD's definitions for the identification of these categories of behavioral health members for standardization purposes.~~

~~(d)~~] (b) The MCO/SE shall proactively identify individuals with special health care needs who have or are at increased risk for a chronic physical [~~and~~] or behavioral health condition.

[~~(e)~~] (c) The MCO/SE shall inform and educate its providers about using the health management programs for the members.

[~~(f) The MCO/SE shall participate with providers to reduce inappropriate use of psychopharmacological medications and adverse drug reactions.~~

~~(g) The MCO/SE shall periodically update its providers regarding best practices and on the procedures for appropriate healthcare referral.~~]

(d) The MCO/SE shall facilitate, through their committee structure, a process for identifying and addressing the appropriate use of psychopharmacological medications and adverse drug reactions.

(2) The MCO/SE shall pursue continuity of care for members.

[~~(a) The MCO/SE shall report changes in its provider network to HSD.~~

~~(b) The MCO/SE shall have a defined health delivery process to promote a high level of member compliance with follow-up appointments, consultations/referrals and diagnostic laboratory, diagnostic imaging and other testing.~~

~~(c)~~] (a) The MCO/SE shall have a defined process to ensure prompt member notification by its providers of abnormal results of diagnostic laboratory, diagnostic imaging and other testing and this will be documented in the medical record.

[~~(d)~~] (b) The MCO/SE shall ensure that the processes for follow-up visits, consultations and referrals are consistent with high quality care and service and do not create a clinically significant impediment to timely medically necessary services. The determination of medical necessity shall be based on HSD's medical necessity definition and its application.

[~~(e) The MCO/SE shall ensure that all medically necessary referrals are arranged and coordinated by either the referring provider or by the MCO/SE's care coordination unit.~~

~~(f) The MCO/SE shall implement policies and procedures to ensure that continuity and coordination of care occur across practices, provider sites and between the MCO/SE. In particular, the MCO/SE shall coordinate, in accordance with applicable state and federal privacy laws, with other state agencies such as DOH, CYFD protective services and juvenile justice, corrections community reentry services, as well as, with the schools. In addition, the SE shall coordinate services with all applicable state agencies comprising the collaborative.~~

~~(g) The MCO/SE shall assist and monitor for continuity of care the transitions between providers in order to avoid abrupt changes in treatment plan and caregiver for members currently being served.~~

~~(3) At the request of a member or legal guardian, the MCO/SE shall provide information on options for converting coverage to a different insurance to members whose enrollment is terminated due to loss of medicaid eligibility and this shall be documented.~~]

(c) The MCO/SE shall develop a policy and procedure that addresses the education of the member and promotes compliance with follow up appointments, consultation/referrals and diagnostic laboratory, imaging and other testing.

G. **Clinical practice guidelines:** The MCO/SE shall disseminate recommended practice guidelines, practice parameters, consensus statements and specific criteria for the provision of acute and chronic physical and behavioral health care services.

(1) The MCO/SE shall select the clinical issues to be addressed with clinical guidelines based on the needs of the medicaid populations.

(2) The clinical practice guidelines shall be evidence-based.

(3) The MCO/SE shall involve board certified providers from its network who are appropriate to the clinical issue in the development and adoption of clinical practice guidelines.

(4) The MCO/SE shall develop a mechanism for reviewing the guidelines when clinically appropriate, but at least every two years, and updating them as necessary.

(5) The MCO/SE shall distribute the guidelines to the appropriate providers and, upon request, to HSD [~~, upon request~~].

[~~(6) The MCO/SE shall annually measure practitioner performance against at least two important aspects of three clinical practice guidelines and determine consistency of decision-making based on the clinical practices guidelines.~~

~~(7)~~] (6) Decision-making in utilization management, member education, interpretation of covered benefits and other areas shall be consistent with those guidelines.

[~~(8)~~] (7) The [~~MCOs~~] MCO/SE shall implement targeted disease management protocols [~~and procedures~~] for chronic diseases or conditions [~~, such as asthma, diabetes, and hypertension~~] that are appropriate to meet the needs of the varied medicaid populations. [~~The SE shall implement targeted disease management protocols and procedures for chronic diseases or conditions, such as bipolar disorder, depression, and schizophrenia that are appropriate to meet the needs of the varied medicaid populations.~~]

H. **Quality assessment and performance improvement:** The MCO/SE shall achieve required minimum performance levels on performance measures, as established by HSD. [~~and by CMS, on certain quality performance measures and projects. These required levels of performance would address a broad spectrum of key aspects of enrollee care and services. These~~] The quality measures [~~may change from year to year and~~] may be used in part to determine the MCO assignment algorithm. [~~In addition, the MCO shall provide HSD with copies of all studies performed for national accreditation such as NCQA. The SE shall annually provide HSD with copies of its QM/QI studies including its data analysis.~~]

(1) [~~An agreed upon number of disease~~] Disease management/performance measures shall be identified [~~by HSD, in consultation with the MCO, at the beginning of each contract year. The MCO/SE shall achieve minimum performance levels set by HSD for each performance measure. Examples of quality measures used in performance improvement projects may include: EPSDT screening rates, childhood and adolescent immunization rates, ER visits or adherence to grievance resolution timeframes. The SE shall implement the required number of targeted disease management programs as defined by HSD such as depression, bipolar disorder and co-occurring disorders.~~] at the beginning of each contract year by HSD.

(2) The MCO/SE shall measure its performance, using claims, encounter data and other predefined sources of information, and report its performance on each measure to HSD at a frequency to be determined by HSD.

[~~I. **Intervention and follow-up for clinical and service issues:** The MCO/SE shall have a process and take action to improve quality by addressing opportunities for improving performance identified through clinical and service QI activities, as appropriate, and shall also assess the effectiveness of the interventions through systematic follow-up.~~

~~(1) The MCO/SE shall implement~~

~~interventions to improve practitioner and system performance as appropriate.~~

~~(2) The MCO/SE shall implement appropriate corrective interventions when it identifies individual occurrences of poor or substandard quality, especially regarding health and safety issues.~~

~~(3) The MCO/SE shall implement appropriate corrective interventions when it identifies underutilization or overutilization.~~

~~J.~~] I. **Effectiveness of the [~~QI~~] QM/QI program:** The MCO/SE shall evaluate the overall effectiveness of its [~~QI~~]QM/QI program and demonstrate improvements in the quality of clinical care and the quality of service to its members. An annual written evaluation, submitted to HSD, shall include a description of completed and ongoing quality improvement activities; trending of measures; and, analysis of demonstrated improvement of identified opportunities for improvement.

[~~(1) The MCO/SE shall perform an annual written evaluation of the QI program and provide a copy to HSD for CMS review. This evaluation shall include at least the following:~~

~~(a) a description of completed and ongoing QI activities;~~

~~(b) trending of measures to assess performance in quality of clinical care and quality of service;~~

~~(c) an analysis of whether there have been demonstrated improvements in the quality of clinical care and quality of service; and~~

~~(d) an evaluation of the overall effectiveness of the QI program.~~

~~(2) There shall be evidence that QI activities have contributed to meaningful improvement in the quality of clinical care and quality of service, including preventive health care, provided to members.~~]

[8.305.8.12 NMAC - Rp 8 NMAC 4.MAD.606.7.2, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-08; A, 7-1-09]

8.305.8.13 STANDARDS FOR UTILIZATION MANAGEMENT: [~~New Mexico medicaid requires appropriate utilization management (UM) standards to be implemented as well as activities to be performed so that excellent services are provided in a coordinated fashion with neither over nor under-utilization.~~] The MCO/SE's UM programs shall be based on standard external national criteria, where available, and established clinical criteria[~~, which are~~] congruent with HSD's medical necessity service definition [~~as defined in 8.305.1 NMAC and are applied consistently in UM decisions by the MCO/SE~~]. The MCO/SE shall request approval from HSD of all UM and level of care criteria. Utilization management (UM) standards shall be applied consistently so services are provided in a coordinated fashion with neither over nor under-utilization. The MCO/SE's utilization management program shall assign responsibility to appropriately qualified, educated, trained, and experienced individuals [~~in order to manage the use of limited resources; to maximize the effectiveness of care by evaluating clinical appropriateness;~~] to authorize [~~the type and volume of~~] services through fair, consistent and culturally competent decision making [~~; and~~] to assure equitable access to care. These standards shall also apply to pharmacy utilization management including the formulary exception process. Services provided within the IHS and tribal 638 networks are not subject to prior authorization requirements, except for behavioral health residential treatment center (RTC) services.

A. **Program design:**

(1) A written description of the UM program shall outline the program structure and include a clear definition of authority and accountability for all activities between the MCO and entities to which the MCO/SE delegates UM activities.

(2) A designated physician and a behavioral health care physician for the SE shall have substantial involvement in the design and implementation of the UM program.

(3) The description shall include the scope of the program; the processes and information sources used to determine benefit coverage; clinical necessity, appropriateness and effectiveness; policies and procedures to evaluate care coordination, discharge criteria, [~~site of services,~~] levels of care, triage decisions and cultural competence of care delivery; processes to review, approve and deny services; and processes to evaluate service outcomes; and including a plan to improve outcomes, as needed. [~~The above service definitions are to be no less than the amount, duration and scope for the same services furnished to members under fee-for-service medicaid as set forth in 42 CFR Section 440.230.~~

~~(4) The MCO/SE shall ensure that the services are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. The MCO/SE may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the beneficiary's diagnosis, type of illness, or condition.~~

~~(5)~~] (4) The UM program shall be evaluated and approved annually by senior management and the medical (or behavioral health) director or the QI committee.

[~~(6)~~] (5) The UM program shall include policies and procedures for monitoring inter-rater reliability of all individuals performing UR review. The procedures shall include a monitoring and education process for all UR staff identified as not meeting 90[~~%~~] percent agreement on test cases, until adequately resolved.

B. **UM decision criteria:** [~~To make utilization decisions, the~~] The MCO/SE shall use written utilization review decision criteria that are based on reasonable medical evidence, consistent with the New Mexico medicaid definition for medically necessary services, and that are applied in a fair, impartial and consistent manner [~~to serve the best interests of all members~~].

(1) [~~UM decisions shall be based on reasonable and scientifically valid utilization review criteria that are objective and measurable, insofar as practical.~~] The MCO/SE shall ensure that the services are no less than the amount, duration and scope for the same services furnished to members under fee-for-service medicaid as set forth in 42 CFR Section 440.230. The MCO/SE may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the beneficiary's diagnosis, type of illness or condition.

(2) The criteria for determining medical necessity shall be academically defensible[~~; based on national standards of practice when such standards are available; involve appropriate practitioners when developing, adopting and reviewing criteria; and acceptable to the MCO/SE's medical (or behavioral health) director, peer consultants and relevant local providers~~]. The MCO/SE shall specify what constitutes medically necessary services in a manner that is no more restrictive than that used by HSD [~~as indicated in state statutes and regulations~~]. [~~According to this definition, the~~] The MCO/SE must be responsible for covered services related to [~~the following~~]:

(a) the prevention, diagnosis, and treatment of health impairments; and

(b) the ability to attain, maintain, or regain functional capacity.

(3) Criteria for determination of medical appropriateness shall be clearly documented.

(4) The MCO/SE shall maintain evidence that [~~it has reviewed~~] the criteria has been reviewed and updated at specified intervals [~~and that the criteria have been updated, as necessary~~].

(5) The MCO/SE shall state in writing how practitioners can obtain UM criteria and shall provide criteria to its practitioners upon request. The MCO/SE shall have written policies and procedures describing how health professionals may access the clinical information used to support UM decisions and the specific clinical information that a provider must make available to an MCO to support a UM decision.

C. **Authorization of services:** [~~For the processing of requests for initial and continuing authorization of servic-~~

~~es, the~~] The MCO/SE shall:

(1) have a policy and procedure in place for authorization requests and decisions;

(2) require [~~that its~~] subcontractors have [~~in place~~]written policies and procedures for authorization requests and decisions;

(3) [~~have in effect a mechanism to~~]ensure consistent application of review criteria for authorization decisions; and

(4) consult with requesting providers when appropriate.

D. **Use of qualified professionals:** The MCO/SE shall [~~have written policies and procedures explaining how qualified health professionals shall assess the clinical information used to support UM decisions.~~] utilize appropriately licensed and experienced health care practitioners whose education, training, experience and expertise are commensurate with the UM reviews and are qualified to supervise review decisions. Denials based on medical necessity shall be made by a designated physician for the UM program. The reason for the denial shall be cited.

[~~(1) Appropriately licensed and experienced health care practitioners whose education, training, experience and expertise are commensurate with the UM reviews conducted shall supervise review decisions.~~

~~(2) Denials based on medical necessity shall be made by a designated physician for the UM program. The reason for the denial shall be cited.~~

~~(3) For a health service determined to be medically necessary, but for which the level of care (setting) is determined to be inappropriate, the MCO/SE shall approve the appropriate level of care as well as deny that which was determined to be inappropriate.~~

~~(4) The reasons for review decisions (approve/deny) shall be clearly documented and communicated to the requesting practitioner responsible for justifying the medical necessity.~~]

E. **Timeliness of decisions and notifications:** The MCO/SE shall make utilization decisions and notifications in a timely manner that accommodates the clinical urgency of the situation and shall minimize disruption in the provision and continuity of health care services. The following time frames are required and shall not be affected by "pend" decisions.

(1) **Precertification - routine:**

(a) **Decision:** For precertification of non-urgent (routine) care, the MCO/SE shall make a decision within 14 calendar days from receipt of request for service.

(b) **Notification:** For authorization or denial of non-urgent (routine) care, the MCO/SE shall notify a provider of the decision within one working day of making the decision.

(c) **Confirmation - denial:** For denial of non-urgent (routine) care, the MCO/SE shall give the member and provider written or electronic confirmation of the decision within two working days of making the decision.

(2) **Precertification - urgent:**

(a) **Decision and notification:** For precertification of urgent care, the MCO/SE shall make a decision and notify the provider of the decision within 72 hours of receipt of request. For authorization of urgent care that results in a denial, the MCO/SE shall notify both the member and provider that an expedited appeal has already occurred.

(b) **Confirmation - denial:** For denial of urgent care, the MCO/SE shall give the member and provider written or electronic confirmation of the decision within two working days of making the decision. The MCO/SE shall provide written confirmation of its decision within two working days of providing notification of a decision if the initial notification was not in writing.

(3) **Precertification - residential services (SE only):** For precertification of RTC, TFC and group home, the SE shall make a decision within five working days from receipt of request for service.

(4) **Precertification - extensions:** For precertification decisions of non-urgent or urgent care, a 14 calendar day extension may be requested by the member or provider. A 14 calendar day extension may also be requested by the MCO/SE. The MCO/SE must justify in the UM file the need for additional information and that the 14 day extension is in the member's interest.

(5) **Concurrent - routine:**

(a) **Decisions:** For concurrent review of routine services, the MCO/SE shall make a decision within 10 working days of the receipt of the request.

(b) **Notification:** For authorization or denial of routine continued stay, the MCO/SE shall notify a provider of the decision within one working day of making the decision.

(c) **Confirmation - denial:** For denial of routine continued stay, the MCO/SE shall give the member and provider written or electronic confirmation within one working day of the decision. The MCO/SE shall provide written confirmation of its decision within two working days of providing notification of a decision if the initial notification was not in writing.

(6) **Concurrent - urgent:**

(a) **Decision:** For concurrent review of urgent services, the MCO/SE shall make a decision within one working day of receipt of request.

(b) **Notification:** For authorization or denial of urgent continued stay, the MCO/SE shall notify a provider of the decision within one working day of making the decision. The MCO/SE shall initiate an expedited appeal for all denials of concurrent urgent services.

(c) **Confirmation - denial:** For denial of urgent continued stay, the MCO/SE shall give the member and provider written or electronic confirmation within one working day of the decision. The MCO/SE shall provide written confirmation of its decision within two working days of providing notification of a decision if the initial notification was not in writing.

(7) **Concurrent - residential services (SE only):** For concurrent reviews of RTC, TFC and group home, the SE shall make a decision within five working days from receipt of request for service. Timelines for routine and urgent concurrent shall apply.

(8) **Administrative/technical denials:** When the MCO/SE denies a request for services due to the requested service not being covered by medicaid or due to provider noncompliance with the MCO/SE's administrative policies, the MCO/SE shall adhere to the timelines cited above for decision making, notification and written confirmation.

F. **Use of clinical information:** When making a determination of coverage based on medical necessity, the MCO/SE shall obtain relevant clinical information and consult with the treating practitioner, as appropriate.

(1) A written description shall identify the information required and collected to support UM decision making.

(2) A thorough assessment of the member's needs based on clinical appropriateness and necessity shall be performed.

(3) There shall be documentation that relevant clinical information is gathered consistently to support UM decision making. The MCO/SE UM policies and procedures will clearly define in writing for providers what constitutes relevant clinical information.

(4) The clinical information requirements for UM decision making shall be made known in advance to relevant treating providers.

G. **Denial of services:** A "denial" is a [~~nonauthorization~~] non-authorization of a request for care or services. The MCO/SE shall clearly document in the UR file a reference to the provision guideline, protocol or other criteria on which the denial decision is based, and communicate the reason for each denial.

(1) The MCO/SE shall require that any decision to deny a service authorization request or to authorize a service in an

amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease, such as the MCO/SE medical director.

(2) For a health service determined to be medically necessary, but for which the level of care (setting) is determined to be inappropriate, the MCO/SE shall deny that which was determined to be inappropriate, and provide an appropriate alternative level of care (setting) which would be covered.

(3) The reasons for review decisions (approve/deny) shall be clearly documented and communicated to the requesting practitioner.

(4) The MCO/SE shall send written notification to the member of the reason for each denial based on medical necessity and to the provider, as appropriate.

[~~(2)~~] (5) The MCO/SE shall make available to a requesting provider a physician reviewer to discuss, by telephone, denial decisions based on medical necessity.

[~~(3) The MCO/SE shall send written notification to the member of the reason for each denial based on medical necessity and to the provider, as appropriate.~~

~~(4)~~] (6) The MCO/SE shall recognize that a utilization review decision made by the designated HSD official resulting from a fair hearing is final and shall be honored by the MCO/SE, unless the MCO/SE successfully appeals the decision through judicial hearing or arbitration.

H. **Compensation for UM activities:** Each MCO/SE contract must provide that, consistent with 42 CFR Sections 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

I. **Evaluation and use of new technologies:** The MCO/SE and its delegates shall evaluate the inclusion of new medical technology and the new applications of existing technology in the benefit package. This includes the evaluation of clinical procedures and interventions, drugs and devices.

(1) The MCO/SE shall have a written description of the process used to determine whether new medical technology and new uses of existing technologies shall be included in the benefit package.

(a) The written description shall include the decision variables used by the MCO/SE to evaluate whether new medical technology and new applications of existing technology shall be included in the benefit package.

(b) The process shall include a review of information from appropriate government regulatory bodies as well as published scientific evidence.

(c) Appropriate professionals shall participate in the process to decide whether to include new medical technology and new uses of existing technology in the benefit package.

(2) An MCO/SE shall not deem a technology or its application as experimental, investigational or unproven and deny coverage unless that technology or its application fulfills the definition of "experimental, investigational or unproven" contained in 8.325.6 NMAC, *Experimental or Investigational Procedures, Technologies or Therapies*.

J. **Evaluation of the UM process:** The MCO/SE shall evaluate member and provider satisfaction with the UM process based on member and provider satisfaction survey results. The MCO/SE shall forward the evaluation results to HSD.

K. **HSD access:** HSD shall have access to the MCO/SE's UM review documentation on request.

[8.305.8.13 NMAC - Rp 8 NMAC 4.MAD.606.7.4, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-08; A, 7-1-09]

8.305.8.14 STANDARDS FOR CREDENTIALING AND RECREDENTIALING: The MCO/SE shall document the mechanism for credentialing and recredentialing of providers with whom it contracts or employs to treat members outside the in-patient setting and who fall under its scope of authority [~~and action~~]. [~~This~~] The documentation shall include, but not be limited to, defining the scope of providers covered, the criteria and the primary source verification of information used to meet the criteria, the process used to make decisions [~~that may not be discriminatory~~], and the extent of delegated credentialing or recredentialing arrangements. The credentialing process shall be completed within [~~180~~] 45 days from receipt of completed application with all required documentation unless there are extenuating circumstances. The MCOs shall all use the same primary source verification entity or one entity for the collection and storage of provider credentialing application information unless there are more cost effective alternatives approved by HSD.

A. **Practitioner participation:** The MCO/SE shall have a process for receiving input from participating providers regarding credentialing and recredentialing of providers.

B. **Primary source verification:** [~~At the time of credentialing the provider, the~~] The MCO/SE shall verify the following information from primary sources during credentialing:

(1) a current valid license to practice;

(2) the status of clinical privileges at the institution designated by the practitioner as the primary admitting facility, if applicable;

(3) valid drug enforcement agency (DEA) or controlled substance registration (CSR) certificate, if applicable;

(4) education and training of providers, including graduation from an accredited professional program and the highest training program applicable to the academic or professional degree, discipline and licensure of the practitioner;

(5) board certification if the practitioner states on the application that the practitioner is board certified in a specialty; [~~and~~]

(6) current, adequate malpractice insurance, according to the MCO/SE's policy and history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and

(7) primary source verification shall not be required for work history.

C. **Credentialing application:** The MCO/SE shall use the HSD-approved credentialing form. The provider shall complete a credentialing application that includes a statement by the applicant regarding:

(1) ability to perform the essential functions of the positions, with or without accommodation;

(2) lack of present illegal drug use;

(3) history of loss of license and felony convictions;

(4) history of loss or limitation of privileges or disciplinary activity;

(5) sanctions, suspensions or terminations imposed by medicare or medicaid; and

(6) applicant attests to the correctness and completeness of the application.

D. **External source verification:** Before a practitioner is credentialed, the MCO/SE shall receive information on the practitioner from the following organizations and shall include the information in the credentialing files:

(1) national practitioner data bank, if applicable to the practitioner type;

(2) information about sanctions or limitations on licensure from the following agencies, as applicable:

(a) state board of medical examiners, state osteopathic examining board, federation of state medical boards or the department of professional regulations;

(b) state board of chiropractic examiners or the federation of chiropractic licensing boards;

(c) state board of dental examiners;

(d) state board of podiatric examiners;

(e) state board of nursing;

(f) the appropriate state licensing board for other practitioner types, including behavioral health; and

(g) other recognized monitoring organizations appropriate to the practitioner's discipline;

(3) HHS/OIG exclusion from participation in medicare, medicaid, the state children's health insurance plan (SCHIP), and all federal health care programs (as defined in section 1128B(f) of the Social Security Act; sanctions by medicare, [~~and medicaid , as applicable.~~] medicaid, the state children's health insurance program or any federal care program.

E. **Evaluation of practitioner site and medical records.** [~~At the time of credentialing the~~] The MCO shall perform an initial visit to the offices of potential primary care providers, obstetricians, and gynecologists[~~. The~~] and the SE shall perform an initial visit to the offices of potential high volume behavioral health care practitioners, prior to acceptance and inclusion as participating providers. The MCO/SE shall determine its method for identifying high volume behavioral health practitioners.

(1) The MCO/SE shall document a structured review to evaluate the site against the MCO's organizational standards and those specified by the managed care contract.

(2) The MCO/SE shall document an evaluation of the medical record keeping practices at each site for conformity with the MCO/SE's organizational standards.

F. **Recredentialing:** The MCO/SE shall have formalized recredentialing procedures.

(1) The MCO/SE shall [~~formally~~] recredential its providers at least every three years. [~~During the recredentialing process the~~] The MCO/SE shall verify the following information from primary sources during recredentialing:

(a) a current valid license to practice;

(b) the status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;

(c) valid DEA or CSR certificate, if applicable;

(d) board certification, if the practitioner was due to be recertified or became board certified since last credentialed or recredentialed;

(e) history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and

(f) a current, signed attestation statement by the applicant regarding:

(i) ability to perform the essential functions of the position, with or without accommodation;

(ii) lack of current illegal drug use;

(iii) history of loss or limitation of privileges or disciplinary action; and

(iv) current professional malpractice insurance coverage.

(2) There shall be evidence that, before making a recredentialing decision, the MCO has received information about sanctions or limitations on licensure from the following agencies, if applicable:

(a) the national practitioner data bank;

(b) medicare and medicaid;

(c) state board of medical examiners, state osteopathic examining board, federation of state medical boards or the department of professional regulations;

(d) state board of chiropractic examiners or the federation of chiropractic licensing boards;

(e) state board of dental examiners;

(f) state board of podiatric examiners;

(g) state board of nursing;

(h) the appropriate state licensing board for other practitioner types; [~~and~~]

(i) other recognized monitoring organizations appropriate to the practitioner's discipline; and

(j) HHS/OIG exclusion from participation in medicare, medicaid, the state children's health insurance program and all federal health care programs.

(3) The MCO/SE shall incorporate data from the following sources in its recredentialing decision-making process for providers:

(a) member grievances and appeals;

(b) information from quality management and improvement activities; and

(c) medical record reviews conducted under Subsection E of 8.305.8.14 NMAC.

G. **Imposition of remedies:** The MCO/SE shall have policies and procedures for altering the conditions of the practitioner's participation with the MCO/SE based on issues of quality of care and service. These policies and procedures shall define the range of actions that the MCO/SE may take to improve the provider's performance prior to termination.

(1) The MCO/SE shall have procedures for reporting to appropriate authorities, including HSD, serious quality deficiencies that could result in a practitioner's suspension or termination.

(2) The MCO/SE shall have an appeal process by which the MCO/SE may change the conditions of a practitioner's participation based on issues of quality of care and service. The MCO/SE shall inform providers of the appeal process in writing.

H. **Assessment of organizational providers:** The MCO/SE shall have written policies and procedures for the initial and ongoing assessment of organizational providers with whom it intends to contract or which it is contracted. [~~Providers include, but are not limited to, hospitals, home health agencies, nursing facilities, free-standing surgical centers, behavioral, psychiatric and addiction disorder facilities or services, residential treatment centers, clinics, 24-hour programs, behavioral health units of general hospitals and free-standing psychiatric hospitals.~~] At least every three years, the MCO/SE shall: [~~confirm that the provider is in good standing with state and federal regulatory bodies, including HSD, and has been accredited or certified by the appropriate accrediting body and state certification agency or has met standards of participation required by the MCO/SE.~~]

(1) [~~The MCO/SE shall~~] confirm that the provider has been certified by the appropriate state certification agency, when applicable; behavioral health organizational providers and services are certified by the following:

(a) DOH is the certification agency for organizational services and providers that require certification, except for child and adolescent behavioral health services; and

(b) CYFD is the certification agency for child and adolescent behavioral health organizational services and providers that require certification;

(2) [~~The MCO/SE shall~~] confirm that the provider has been accredited by the appropriate accrediting body or has a detailed written plan [~~that could reasonably be~~] expected to lead to accreditation within a reasonable period of time; behavioral health organizational providers and services are accredited by the following:

(a) adult behavioral health organizational services or providers are accredited by the council on accreditation of rehabilitation facilities (CARF);

(b) child and adolescent accredited residential treatment centers are accredited by the joint commission on accreditation of healthcare organizations (JCAHO); other child behavioral health organizational services or providers are accredited by the council on accreditation (COA); and

(c) organizational services or providers who serve adults, children and adolescents are accredited by either CARF or COA.

[8.305.8.14 NMAC - Rp 8 NMAC 4.MAD.606.7.5, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.8.15 MEMBER BILL OF RIGHTS: [~~Under medicaid managed care, members have certain rights and responsibilities and the~~] The MCO/SE shall have policies and procedures governing member rights and responsibilities and require adherence by all providers, including MCO-contracted providers. The following subsections shall be known as the "Member Bill of Rights".

A. **Members' rights:**

(1) Members shall have the right to be treated equitably and with respect and recognition of their dignity and need for privacy.

(2) Members shall have the right to receive health care services in a non-discriminatory fashion.

(3) Members who have a disability shall have the right to receive any information in an alternative format in compliance with the Americans with Disabilities Act.

(4) Members or their legal guardians shall have the right to participate with their health care providers in decision making in all aspects of their health care, including the course of treatment development, acceptable treatments and the right to refuse treatment.

(5) Members or their legal guardians shall have the right to informed consent.

(6) Members or their legal guardians shall have the right to choose a surrogate decision-maker to be involved as appropriate, to assist with care decisions.

(7) Members or their legal guardians shall have the right to seek a second opinion from a qualified health care professional within the MCO/SE network, or the MCO/SE shall arrange for the member to obtain a second opinion outside the network, at no cost to the member. A second opinion may be requested, when the member or member's legal guardian needs additional information regarding recommended treatment or believes the provider is not authorizing requested care.

(8) Members or their legal guardians shall have a right to voice grievances about the care provided by the MCO/SE and to make use of the MCO/SE's grievance process and the HSD fair hearings process without fear of retaliation.

(9) Members or their legal guardians shall have the right to choose from among the available providers within the limits of the plan network and its referral and prior authorization requirements.

(10) Members or their legal guardians shall have the right to make their wishes known through advance directives regarding health care decisions (e.g., living wills, right to die directives, "do not resuscitate" orders, etc.) consistent with federal and state laws and regulations.

(11) Members or their legal guardians shall have the right to access the member's medical records in accordance with the applicable federal and state laws and regulations.

(12) Members or their legal guardians shall have the right to receive information about: the MCO/SE, its health care services, how to access those services, and the MCO/SE network providers.

(13) Members or their legal guardians shall have the right to be free from harassment by the MCO/SE or its network providers in regard to contractual disputes between the MCO/SE and providers.

(14) Members have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal or state of New Mexico regulations on the use of restraints and seclusion.

(15) (MCO only) Members or their legal guardians shall have the right to select an MCO and exercise switch enrollment rights without threats or harassment.

B. **Members' responsibilities:** Members or their legal guardians shall have certain responsibilities that will facilitate the treatment process.

(1) Members or their legal guardians shall have the responsibility to provide, whenever possible, information that the MCO/SE and providers need in order to care for them.

(2) Members or their legal guardians shall have the responsibility to understand the member's health problems and to participate in developing mutually agreed upon treatment goals.

(3) Members or their legal guardians shall have the responsibility to follow the plans and instructions for care that they have agreed upon with their providers or to notify providers if changes are requested.

(4) Members or their legal guardians shall have the responsibility to keep, reschedule or cancel an appointment rather than to simply not show up.

C. **MCO/SE responsibilities:**

(1) The MCO/SE shall provide a member handbook to its members and to potential members who request the handbook and have the handbook accessible via the internet. The MCO/SE shall publish [~~in the member handbook~~] the members' rights and responsibilities from the member bill of rights in the member handbook. MCOs/SE shall honor the provisions set forth in the member bill of rights.

(2) The MCO/SE shall comply with the grievance resolutions process [~~found~~] delineated in 8.305.12 NMAC, *MCO Member Grievance System*.

(3) The MCO/SE shall provide members or legal guardians with updated information within 30 days of a material change in the MCO/SE provider network, procedures for obtaining benefits, the amount, duration or scope of the benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled, and information on grievance, appeal and fair hearing procedures.

(4) The MCO/SE shall provide members and legal guardians with access to a toll-free hot line for the MCO/SE's program for grievance management. The toll-free hot line for grievance management shall include the following features:

(a) requires no more than a two-minute wait except following mass enrollment periods;

(b) does not require a "touch-tone" telephone;

(c) allows communication with members whose primary language is not English or who are hearing impaired; and

(d) is in operation 24 hours per day, seven days per week.

(5) The MCO/SE shall provide active and participatory education of members or legal guardians that takes into account the cultural, ethnic and linguistic needs of members in order to assure understanding of the health care program, improve access and enhance the quality of service provided.

(6) The MCO/SE shall protect the confidentiality of member information and records.

(a) The MCO/SE shall adopt and implement written confidentiality policies and procedures that conform to federal and state laws and regulations.

(b) The MCO/SE's contracts with providers shall explicitly state expectations about confidentiality of member information and records.

(c) The MCO/SE shall afford members or legal guardians the opportunity to approve or deny release by the MCO/SE of identifiable personal information to a person or agency outside the MCO/SE, except when release is required by law, state regulation, court order[~~, HSD quality standards, or in the case of behavioral health, the collaborative~~] or HSD quality standards. HSD shall only use this information consistent with the requirements listed in 45 CFR 164.508.

(d) The MCO/SE shall notify members and legal guardians in a timely manner when information is released in response to a court order.

(e) The MCO/SE shall have written policies and procedures to maintain confidential information gathered or learned during the investigation or resolution of a complaint, including a member's status as a complainant.

(f) The MCO/SE shall have written policies and procedures to maintain confidentiality of medical records used in quality review, measurement and improvement activities.

(7) When the MCO/SE delegates member service activity, the MCO/SE shall retain responsibility for documenting MCO/SE oversight of the delegated activity.

(8) Policies regarding consent for treatment shall be disseminated annually to providers within the MCO/SE network. The MCO/SE shall have written policies regarding the requirement for providers to abide by federal and state law and New Mexico medicaid policies regarding informed consent specific to:

(a) the treatment of minors;

(b) adults who are in the custody of the state;

(c) adults who are the subject of an active protective services case with CYFD;

(d) children and adolescents who fall under the jurisdiction of CYFD; and

(e) individuals who are unable to exercise rational judgment or give informed consent consistent with federal and state laws and New Mexico medicaid regulations.

(9) The MCO/SE shall have a process to detect, measure and eliminate operational bias or discrimination against members. The MCO/SE shall ensure that its providers and their facilities comply with the Americans with Disabilities Act.

[~~(10) The MCO/SE shall provide a member handbook to its members or potential members who request the handbook, and it shall be accessible via the internet.~~

~~(11)~~] (10) The MCO/SE shall develop and implement policies and procedures to allow members to access behavioral health services without going through the PCP. These policies and procedures must afford timely access to behavioral health services.

[~~(12)~~] (11) The MCO shall not restrict a member's right to choose a provider of family planning services.

[~~(13)~~] (12) The MCO/SE's communication with members shall be responsive to the various populations by demonstrating cultural competence in the materials and services provided to members. The MCO/SE shall provide information to its network providers about culturally relevant services and may provide information about alternative treatment options, e.g., American Indian healing practices if available. Information and materials provided by the MCO/SE to medicaid members shall be written at a sixth-grade language level and shall be made available in the prevalent population language.

[8.305.8.15 NMAC - Rp 8 NMAC 4.MAD.606.7.6, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.8.16 STANDARDS FOR PREVENTIVE HEALTH SERVICES: The MCO shall follow current national standards for preventive health services including behavioral health preventive services. [~~These standards~~] Standards are derived from several sources, including the U.S. preventive services task force, the centers for disease control and prevention; and the American college of obstetricians and gynecologists. Any preventive health guidelines developed by the MCO under these standards shall be adopted [~~,~~] and reviewed at least every two years, updated when appropriate and disseminated to practitioner and member. Unless a member refuses and the refusal is documented, the MCO shall provide the following preventive health services or screens or document that the services (with the results) were provided by other means. The MCO shall document medical reasons not to perform these services for an individual member. Member refusal is defined to include refusal to consent to and refusal to access care.

A. **Initial assessment:** The MCO shall perform an initial assessment of the medicaid member's health care needs within 90 days of the date the member enrolls in the MCO. For this purpose, a member is considered enrolled at the lock-in date. This assessment must include a question regarding the member's primary language spoken and written.

B. **Immunizations:** The MCO shall adopt policies that to the extent possible, ensure that within six months of enrollment, members are immunized according to the type and schedule provided by current recommendations of the state department of health [~~advisory committee on immunizations. The MCO shall provide the immunizations or verify the member's immunization history by a method acceptable to the health advisory committee~~]. The MCO shall encourage providers to verify and document all administered immunizations in the New Mexico statewide immunization information system (SIIS).

C. **Screens:** The MCO shall adopt policies which will ensure that, to the extent possible, within six months of enrollment or within six months of a change in screening standards, asymptomatic members receive at least the following preventive screening services.

(1) *Screening for breast cancer*: Females aged 40-69 years shall be screened every one to two years by mammography alone or by mammography and annual clinical breast examination.

(2) *Screening for cervical cancer*: Female members with a cervix shall receive cytopathology testing starting at the onset of sexual activity, but at least by 21 years of age and every three years thereafter until reaching 65 years of age if prior testing has been consistently normal and the member has been confirmed not to be at high risk. If the member is at high risk, the frequency shall be at least annual.

(3) *Screening for colorectal cancer*: Members aged 50 years and older at normal risk for colorectal cancer shall be screened with annual fecal occult blood testing or sigmoidoscopy or colonoscopy or double contrast barium, at a periodicity determined by the MCO.

(4) *Blood pressure measurement*: Members over age 18 shall receive a blood pressure measurement at least every two years.

(5) *Serum cholesterol measurement*: Male members aged 35 and older and female members aged 45 and older who are at normal risk for coronary heart disease shall receive serum cholesterol and HDL cholesterol measurement every five years. Adults aged 20 or older with risk factors for heart disease shall have serum cholesterol and HDL cholesterol measurements.

(6) *Screening for obesity*: Members shall receive body weight and height/length measurements with each physical exam. Children shall receive a BMI percentile designation.

(7) *Screening for elevated lead levels*: Members aged 9-15 months (ideally at 12 months) shall receive a blood lead measurement at least once.

(8) *Screening for tuberculosis*: Routine tuberculin skin testing shall not be required for all members. The following high-risk persons shall be screened or previous screening noted: persons who immigrated from countries in Asia, Africa, Latin America or the Middle East in the preceding five years; persons who have substantial contact with immigrants from those areas; migrant farm workers; and persons who are alcoholic, homeless or injecting drug users. HIV-infected persons shall be screened annually. Persons whose screening tuberculin test is positive ($\geq$10 mm of induration) must be referred to the local public health office in their community of residence for contact investigation.

(9) *Screening for rubella*: All female members of childbearing ages shall be screened for rubella susceptibility by history of vaccination or by serology.

(10) *Screening for chlamydia*: All sexually active female members age 25 or younger shall be screened for chlamydia. All female members over age 25 shall be screened for chlamydia if they inconsistently use barrier contraception, have more than

one sex partner, or have had a sexually transmitted disease in the past.

(11) *Screening for type 2 diabetes*: Individuals with one or more of the following risk factors for diabetes shall be screened. Risk factors include a family history of diabetes (parent or sibling with diabetes); obesity (≥20% over desired body weight or BMI ≥27kg/m2); race/ethnicity (e.g. Hispanic, Native American, African American, Asian-Pacific islander); previously identified impaired fasting glucose or impaired glucose tolerance; hypertension (≥140/90 mmHg); HDL cholesterol level ≤35 mg/dl and triglyceride level ≥250 mg/dl; history of gestational diabetes mellitus (GDM) or delivery of babies over [~~9~~] nine lbs.

(12) *Prenatal screening*: All pregnant members shall be screened for preeclampsia, D(Rh) incompatibility, down syndrome, neural tube defects, hemoglobinopathies, vaginal and rectal group B streptococcal infection and screened and counseled for HIV in accordance with the most current recommendations of the American college of obstetricians and gynecologists.

(13) *Newborn screening*: Newborn members shall be screened for those disorders specified in the state of New Mexico metabolic screen.

(14) *Tot-to-teen health checks*: The MCO shall operate tot-to-teen mandated early and periodic screening, diagnostic and treatment (EPSDT) services as outlined in 8.320.3 NMAC, *Tot-to-Teen Health Checks*. Within three months of enrollment lock-in, the MCO shall ensure that eligible members (up to age 21) are current according to the screening schedule (unless more stringent requirements are specified in these standards). The MCO shall encourage PCPs to assess and document for age, height and gender appropriate weight and for BMI percentage during EPSDT screens to detect and treat evidence of weight or obesity issues in children and adolescents.

(15) Members over age 21 must be screened to detect high risk for behavioral health conditions at their first encounter with a PCP after enrollment.

(16) The MCO shall require PCPs to refer members, whenever clinically appropriate, to behavioral health providers. The MCO/SE shall assist the member with an appropriate behavioral health referral.

D. **Counseling:** The MCO shall adopt policies that shall ensure that applicable asymptomatic members are provided counseling on the following topics unless recipient refusal is documented:

(1) prevention of tobacco use;

(2) benefits of physical activity;

(3) benefits of a healthy diet;

(4) prevention of osteoporosis and heart disease in menopausal women citing the advantages and disadvantages of calcium and hormonal supplementation;

(5) prevention of motor vehicle injuries;

(6) prevention of household and recreational injuries;

(7) prevention of dental and periodontal disease;

(8) prevention of HIV infection and other sexually transmitted diseases;

(9) prevention of unintended pregnancies; and

(10) prevention or intervention for obesity or weight issues.

E. **Hot line:** The MCO/SE shall provide a toll-free clinical telephone hot line function that includes at least the following services and features:

(1) clinical assessment and triage to evaluate the acuity and severity of the member's symptoms and make the clinically appropriate referral; and

(2) prediagnostic and post-treatment health care decision assistance based on symptoms.

F. **Health information line:** The MCO shall provide a toll-free line that includes at least the following services and features:

(1) general health information on topics appropriate to the various medicaid populations, including those with severe and chronic physical and behavioral health conditions; and

(2) preventive/wellness counseling.

G. **Family planning:** The MCO must have a family planning policy. This policy must ensure that members of the appropriate age of both sexes who seek family planning services are provided with counseling and treatment, if indicated, as it relates to the following:

(1) methods of contraception; and

(2) HIV and other sexually transmitted diseases and risk reduction practices.

H. **Prenatal care:** The MCO shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal care consistent with the standards of the American college of obstetrics and gynecology. The program shall include at least the following:

(1) educational outreach to all members of childbearing age;

(2) prompt and easy access to obstetrical care, including an office visit with a practitioner within three weeks of having a positive pregnancy test (laboratory or home) unless earlier care is clinically indicated;

(3) risk assessment of all pregnant members to identify high-risk cases for special management;

(4) counseling that strongly advises voluntary testing for HIV;

(5) case management services to address the special needs of members who have a high risk pregnancy especially if risk is due to psychosocial factors such as substance abuse or teen pregnancy;

(6) screening for determination of need for a post-partum home visit; and

(7) coordination with other services in support of good prenatal care, including transportation, other community services and referral to an agency that dispenses baby car seats free or at a reduced price.

[8.305.8.16 NMAC - Rp 8 NMAC 4.MAD.606.7.7, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.8.17 STANDARDS FOR MEDICAL RECORDS:

A. **Standards and policies:** The MCO/SE shall require that member medical records be maintained on paper or electronic format. Member medical records shall be maintained timely, and be legible, current, detailed and organized to permit effective and confidential patient care and quality review.

(1) The MCO/SE shall have medical record confidentiality policies and procedures in compliance with state and federal guidelines and HIPAA.

(2) The MCO/SE shall have medical record documentation standards that are enforced with its MCO/SE providers and subcontractors and require that records reflect all aspects of patient care, including ancillary services. The documentation standards shall, at a minimum, require the following:

(a) patient identification information (on each page or electronic file);

(b) personal biographical data (date of birth, sex, race or ethnicity (if available), mailing address, residential address, employer, school, home and work telephone numbers, name and telephone numbers of emergency contacts, marital status, consent forms and guardianship information);

(c) date of data entry and date of encounter;

(d) provider identification (author of entry);

(e) allergies and adverse reactions to medications;

(f) past medical history for patients seen two or more times;

(g) status of preventive services provided or at least those specified by HSD, summarized in an auditable form (a single sheet) in the medical record within six months of enrollment;

(h) diagnostic information;

(i) medication history including what has been effective and what has not, and why;

(j) identification of current problems;

(k) history of smoking, alcohol

use and substance abuse;

(l) reports of consultations and referrals;

(m) reports of emergency care, to the extent possible;

(n) advance directive for adults; and

(o) record legibility to at least a peer of the author.

(3) [~~For patients who receive two or more services from a behavioral health provider through the SE within a 12-month period, the documentation standards shall meet medicaid requirements and require that the following items also be included in the medical record in addition to the above:~~] For SE behavioral health patients, documentation shall include all elements listed above in addition to the following:

(a) a mental status evaluation that documents affect, speech, mood, thought content, judgment, insight, concentration, memory and impulse control;

(b) DSM-IV diagnosis consistent with the history, mental status examination or other assessment data;

(c) a treatment plan consistent with diagnosis that has objective and measurable goals and time frames for goal attainment or problem resolution;

(d) documentation of progress toward attainment of the goal; and

(e) preventive services such as relapse prevention and stress management.

(4) The MCO/SE standards for a member's medical record shall include the following minimum detail for individual clinical encounters:

(a) history (and physical examination) for presenting complaints containing relevant psychological and social conditions affecting the patient's behavioral health, including mental health (psychiatric) and substance abuse status;

(b) plan of treatment;

(c) diagnostic tests and the results;

(d) drugs prescribed, including the strength, amount, directions for use and refills;

(e) therapies and other prescribed regimens and the results;

(f) follow-up plans and directions (such as, time for return visit, symptoms that shall prompt a return visit);

(g) consultations and referrals and the results; and

(h) any other significant aspect of the member's physical or behavioral health care.

B. **Review of records:** The MCO/SE shall have a process to systematically review provider medical records to ensure compliance with the medical record standards. The MCO/SE shall institute improvement and actions when standards are not met.

(1) The EQRO shall conduct reviews of a representative sample of medical records from the MCO's primary care providers, obstetricians, and gynecologists. The EQRO shall conduct a review of a representative sample of clinical records from the SE's behavioral health providers to determine compliance with the SE's established medical record standards and goals.

(2) The MCO/SE shall have a mechanism to assess the effectiveness of organization-wide and practice-site [~~follow-up plans to increase~~] compliance with the MCO/SE's established medical record standards and goals.

C. **Access to records:** The MCO/SE shall provide HSD or its designee appropriate access to provider medical records.

(1) The MCO shall ensure that the PCP maintains a primary medical record for each member, which contains sufficient medical information from all providers involved in the member's care, to ensure continuity of care. The MCO shall ensure that providers involved in the member's care have access to the member's primary medical record including the SE, when necessary.

(2) The MCO/SE shall include provisions in its contracts with providers for appropriate access to the MCO/SE's members' medical records for purposes of in-state quality reviews conducted by HSD or its designee, and for making medical records available to physical health and behavioral health care providers[~~, including behavioral health, for each clinical encounter~~].

(3) The MCO shall have a policy that ensures the confidential transfer of medical and dental information [~~to another primary medical, or dental practitioner whenever~~] when a primary medical or dental provider leaves the MCO, the member changes primary medical or dental practitioner or after a member changes enrollment from one MCO [~~and enrolls in~~] to another MCO.

(4) The SE shall have a policy that ensures the confidential transfer of behavioral health information from one practitioner to another [~~whenever~~] when a provider leaves the SE network or [~~whenever~~] the member changes behavioral health provider or practitioner.

(5) The SE shall have a policy that ensures the confidential transfer of behavioral health information from one collaborative agency to another.

[~~(5)~~] (6) The MCO/SE shall forward [~~to HSD or it designee, specific~~] health information from the provider's medical records to HSD or its designee, as requested. [~~Examples of health information will include, but not be limited to, the following:~~

~~(a) the member's principal physical and behavioral health problems, as applicable;~~

~~(b) the member's current medications, dosage amounts and frequency;~~

~~(c) the member's preventive health services history, including behavioral health;~~

~~(d) EPSDT screening results (if the member is under age 21); and~~

~~(e) other information as requested.~~]

[8.305.8.17 NMAC - Rp 8 NMAC 4.MAD.606.7.8, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.8.18 STANDARDS FOR ACCESS:

A. **Ensure access:** The MCO/SE shall establish and follow protocols to ensure the accessibility, availability and referral to health care providers for each medically necessary service. [~~The MCO/SE shall submit documentation to HSD if requested, at least once per year, giving assurances that it has the capacity to serve the expected enrollment in its service area in accordance with HSD standards and in a format acceptable to HSD.~~] The MCO/SE shall provide access to the full array of covered services within the benefit package[~~. If~~] ; if a service is unavailable based on the access guidelines, a service equal to or higher than shall be offered.

B. **Access to urgent and emergency services:** Services for emergency conditions provided by physical health providers, including emergency transportation, urgent conditions, and post-stabilization care shall be covered by the MCO (only within the United States for both physical and behavioral health). The SE shall coordinate all behavioral health transportation with the member's respective MCO. An urgent condition exists when a member manifests acute symptoms and signs that, by reasonable medical judgment, represent a condition of sufficient severity that the absence of medical attention within 24 hours could reasonably result in an emergency condition. Serious impairment of biopsychosocial functioning, imminent out-of-home placement for children and adolescents or serious jeopardy to the behavioral health of the member are considered urgent conditions. An emergency condition exists when a member manifests acute symptoms and signs that, by reasonable lay person judgment, represent a condition of sufficient severity that the absence of immediate medical attention, including behavioral health, could reasonably result in death, serious impairment of bodily function or major organ or serious jeopardy to the over-

all health of the member. Post-stabilization care means covered services related to an emergency medical or behavioral health condition, that are provided after the member is stabilized in order to maintain the stabilized condition and may include improving or resolving the member's condition.

(1) The MCO/SE shall ensure that there is no clinically significant delay caused by the MCO/SE's utilization control measures. Prior authorization is not required for emergency services in or out of the MCO/SE network, and all emergency services shall be reimbursed at the medicaid fee-for-service rate. The MCO/SE shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical or behavioral health condition under the prudent lay person standard, turned out to be non-emergency in nature.

(2) The MCO/SE shall ensure that the member has the right to use any hospital or other licensed emergency setting for emergency care, regardless of whether the provider is contracted with the MCO/SE.

(3) The MCO/SE shall ensure that members have access to the nearest appropriately designated trauma center according to established EMS triage and transportation protocols.

C. **Primary care provider availability:** The MCO shall follow a process that ensures a sufficient number of primary care providers are available to members to allow the members a reasonable choice among providers.

(1) The MCO shall have at least one primary care provider available per 1,500 members and no more than 1,500 members assigned to a single provider unless approved by HSD.

(2) The minimum number of primary care providers from which to choose and the distances to those providers shall vary by county based on whether the county is urban, rural or frontier. Urban counties are: Bernalillo, Los Alamos, Santa Fe and Dona Ana. Frontier counties are: Catron, Harding, DeBaca, Union, Guadalupe, Hidalgo, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, San Miguel and Cibola. Rural counties are those that are not urban or frontier. The standards are as follows:

(a) 90[~~%~~] percent of urban residents shall travel no farther than 30 miles;

(b) 90[~~%~~] percent of rural residents shall travel no farther than 45 miles; and

(c) 90[~~%~~] percent of frontier residents shall travel no farther than 60 miles.

D. **Pharmacy provider availability:** The MCO shall ensure that a sufficient number of pharmacy providers are available to members. The MCO shall ensure that pharmacy services meet geographic access standards based on the member's county of residence. The access standards are as follows:

(1) 90[~~%~~] percent of urban residents shall travel no farther than 30 miles;

(2) 90[~~%~~] percent of rural residents shall travel no farther than 45 miles; and

(3) 90[~~%~~] percent of frontier residents shall travel no farther than 60 miles.

E. **Access to health care services:** The MCO shall ensure that there are a sufficient number of PCPs and dentists available to members to allow members a reasonable choice. The SE shall ensure that there are a sufficient number of behavioral health providers, based on the least restrictive, medically necessary needs of its members, available statewide to members to allow members a reasonable choice.

(1) The MCO shall report to HSD all provider groups, health centers and individual physician practices and sites in their network that are not accepting new medicaid members. The SE shall report to HSD all individual providers, provider groups, provider agencies or facilities and corresponding sites in its network that are not accepting new medicaid members.

(2) (MCO only) For routine, asymptomatic, member-initiated, outpatient appointments for primary medical care, the request-to-appointment time shall be no more than 30 days, unless the member requests a later time.

(3) (MCO only) For routine asymptomatic member-initiated dental appointments, the request to appointment time shall be consistent with community norms for dental appointments.

(4) (MCO only) For routine, symptomatic, member-initiated, outpatient appointments for nonurgent primary medical and dental care, the request-to-appointment time shall be no more than 14 days, unless the member requests a later time.

(5) (SE only) For nonurgent behavioral health care, the request-to-appointment time shall be no more than 14 days, unless the member requests a later time.

(6) (MCO/SE) Primary medical, dental and behavioral health care outpatient appointments for urgent conditions shall be available within 24 hours.

(7) (MCO only) For specialty outpatient referral and consultation appointments, excluding behavioral health, which is addressed in (5) above, the request-to-appointment time shall generally be consistent with the clinical urgency, but no more than 21 days, unless the member requests a later time.

(8) (MCO only) For routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, the request-to-appointment time shall be consistent with the clinical urgency, but no more than 14 days, unless the member requests a later time.

(9) (MCO only) For outpatient diagnostic laboratory, diagnostic imaging and other testing, if a "walk-in" rather than an appointment system is used, the member wait time shall be consistent with severity of the clinical need.

(10) (MCO only) For urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability shall be consistent with the clinical urgency, but no longer than 48 hours.

(11) (MCO/SE) The in-person prescription fill time (ready for pickup) shall be no longer than 40 minutes. A prescription phoned in by a practitioner shall be filled within 90 minutes.

(12) (MCO/SE) The timing of scheduled follow-up outpatient visits with practitioners shall be consistent with the clinical need.

(13) The MCO/SE shall ensure that a medically necessary pharmaceutical agent is provided in a clinically timely manner.

(14) The MCO/SE's preferred drug list (PDL) shall follow HSD guidelines in Subsection O of 8.305.7.11 NMAC, *Services Included in the Salud! Benefit Package*, *Pharmacy Services*.

(15) The MCO shall approve or deny a request for new durable medical equipment (DME) or for repairs to existing DME owned or rented by the member within seven working days of the request date.

(a) All new customized or made-to-measure DME or customized modifications to existing DME owned or rented by the member shall be delivered to the member within 150 days of the request date.

(b) All standard DME shall be delivered within 24 hours of the request, if needed on an urgent basis.

(c) All standard DME not needed on an urgent basis shall be delivered within a time frame consistent with clinical need.

(d) All DME repairs or non-customized modifications shall be delivered within 60 days of the request date.

(e) The MCO shall have an emergency response plan for non-customized DME needed on an emergent basis.

(16) The MCO shall approve or deny a request for prescribed medical supplies within seven working days of the request date. The MCO shall ensure that:

(a) members can access prescribed medical supplies within 24 hours when needed on an urgent basis;

(b) members can access routine medical supplies within a time frame consistent with the clinical need;

(c) subject to any requirements to procure a physician's order to provide supplies to the member, members utilizing

medical supplies on an ongoing basis shall submit to the MCO lists of needed supplies monthly; and the MCO or its subcontractor shall contact the member if the requested supplies cannot be delivered in the time frame expected and make other delivery arrangements consistent with clinical need.

(17) The MCO shall ensure that members and members' families receive proper instruction on the use of DME and medical supplies provided by the MCO/SE or its subcontractor.

F. **Access to transportation services:** The MCO shall provide the transportation benefit for medically necessary physical and behavioral health. The MCO shall coordinate behavioral health transportation services with the SE[~~, and the SE shall coordinate transportation services with the member's respective MCO~~]. The MCO shall have sufficient transportation providers available to meet the needs of members, including an appropriate number of handivans available for members who are wheelchair or ventilator dependant or have other equipment needs. The MCO shall develop and implement policies and procedures to ensure that:

(1) transportation arranged is appropriate for the member's clinical condition;

(2) the history of services is available at the time services are requested to expedite appropriate arrangements;

(3) CPR-certified drivers are available to transport members consistent with clinical need;

(4) the transportation type is clinically appropriate, including access to non-emergency ground ambulance carriers;

(5) members can access and receive authorization for medically necessary transportation services under certain unusual circumstances without advance notification; and

(6) minors are accompanied by a parent or legal guardian as indicated to provide safe transportation.

G. **Use of technology:** The MCO/SE is encouraged to use state-of-the-art technology, such as telemedicine, to ensure access and availability of services statewide.

[8.305.8.18 NMAC - Rp 8 NMAC 4.MAD.606.7.9, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.8.19 DELEGATION: Delegation is a process whereby an MCO/SE gives another entity the authority to perform certain functions on its behalf. The MCO/SE is fully accountable for all predelegation and delegation activities and decisions made. The MCO/SE shall document its oversight of the delegated activity. The SE may assign, transfer, or delegate to a subcontractor key management functions including, but not limited to, care coordination and universal credentialing with the explicit written approval of HSD [~~and the collaborative with the written approval of the MCO~~].

A. A mutually agreed upon document between MCO/SE and the delegated entity shall describe:

(1) the responsibilities of the MCO/SE and the entity to which the activity is delegated;

(2) the delegated activity;

(3) the frequency and method of reporting to the MCO/SE;

(4) the process by which the MCO/SE evaluates the delegated entity's performance; and

(5) the remedies up to, and including, revocation of the delegation, available to the MCO/SE if the delegated entity does not fulfill its obligations.

B. The MCO/SE shall document evidence that the MCO/SE:

(1) evaluated the delegated entity's capacity to perform the delegated activities prior to delegation;

(2) evaluates regular reports and proactively identifies opportunities for improvement; and

(3) evaluates at least semi-annually the delegated entity's activities in accordance with the MCO/SE's expectations and HSD's standards.

[8.305.8.19 NMAC - N, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.9 NMAC, Sections 8, 9, 10 and 11, which will be effective July 1, 2009.

8.305.9.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost-effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.

[8.305.9.8 NMAC - Rp 8.305.9.8 NMAC, 7-1-04; A, 7-1-09]

8.305.9.9 COORDINATION OF SERVICES:

A. The MCO/SE shall develop and implement policies and procedures to ensure access to care coordination for individuals with special health care needs (ISHCN) as defined in 8.305.15.9 NMAC, *Services for Individuals with Special Health Care Needs (ISHCN)*. Care coordination is defined as [~~a service to assist members with special health care needs, on an as needed basis. It is member-centered, family focused when appropriate, culturally competent and strength based.~~] an office-based administrative function to assist members at risk for adverse outcomes to help meet their needs by filling the gaps in current health care on an as needed basis. Care coordination is member-centered, consumer-directed and family-focused, culturally competent, strengths-based and ensures that medical and behavioral health needs are identified. Services are provided and coordinated with the member and family, as appropriate. Care coordination involves, but is not limited to, the following: planning treatment strategies; monitoring outcomes and resource use; coordinating visits with subspecialists; organizing care to avoid duplication of diagnostic tests and services; sharing information among health care professionals and family; facilitating access to services; actively managing transition of care such as hospital discharge; training caregivers; and ongoing reassessment and refinement of the care plan. Care coordination can help to ensure that the physical and behavioral health needs of the medicaid population are identified and services are provided and coordinated with all service providers, individual members and family, if appropriate, and authorized by the member. Care coordination operates within the MCO/SE with a dedicated care coordination staff functioning independently, but is structurally linked to the other MCO/SE systems, such as quality assurance, member services and grievances. Care coordination is not "gate keeping" or "utilization management". Clinical decisions shall be based on the medically necessary covered services and not fiscal considerations. If both physical and behavioral health conditions exist, the primary care coordination responsibility lies with the condition that is most acute. The MCO/SE responsible for the care of the most acute condition shall be primary lead on care coordination activities with necessary assistance and collaboration from both entities. Care shall be coordinated between both physical health MCO staff and behavioral health SE staff. The MCO/SE shall conduct the following system processes for care coordination:

(1) identify proactively the eligible populations;

(2) identify proactively the needs of the eligible population;

(3) provide a designated person to be primarily responsible for coordinating the health services furnished to a specific member and to serve as the single point of contact for the member; and

(4) ensure access to care coordination for all medicaid eligible ISHCN, as

required by federal regulations.

B. The care coordinator shall be responsible for the following activities:

(1) communicate to the member the care coordinator's name and how to contact this person;

(2) ensure and coordinate access to a qualified provider who is responsible for developing and implementing a comprehensive treatment plan as per applicable provider regulations;

(3) ensure appropriate coordination between physical and behavioral health services and non-managed care services; and, in the case of the SE, also coordinate care among other applicable agencies in the collaborative;

(4) coordinate the needs and identify the status of co-managed cases with either the MCO physical health care coordinator or the SE behavioral health care coordinator;

(5) monitor progress of members to ensure that medically necessary services are received, to assist in resolving identified problems, and to prevent duplication of services;

(6) (SE ONLY) coordinate the provision of necessary services and actively assist members in obtaining such services when a local community case manager is not available;

(7) (SE ONLY) develop a member's individual plan of care (care coordination plan) with involvement from the member and family/guardian (as appropriate) based on a comprehensive assessment of the goals, capabilities and the behavioral health service needs of the member and with consideration of the needs and goals of the family (if appropriate); provide for an evaluation process of the plan that measures the member's response to care and ensures revision of the plan as needed;

(8) (MCO ONLY) ensure the development of a member's individual plan of care, based on a comprehensive assessment of the goals, capabilities and medical condition of the member and with consideration of the needs and goals of the family; provide for an evaluation process that measures the member's response to care and ensures revision of the plan as needed;

(9) involve the member and family in the development of the plan of care, as appropriate; a member or family shall have the right to refuse care coordination or case management, that will be documented in the care coordination file; and

(10) [~~ensure~~] verify that all necessary information is shared with key providers [~~with the member's written permission or documented verbal permission~~] to facilitate the delivery of optimum care; the MCO/SE shall ensure and document that the releasing provider has obtained either written or documented verbal permission from the member for the release of information; this information sharing is required [~~to ensure optimum care and~~] communication between primary care and behavioral health care, as well as among involved behavioral health providers and across other service providing systems.

C. For clarification purposes, activities provided through care coordination at the MCO/SE level differ from case management activities provided as part of the targeted case management programs included in the medicaid benefit package. These external case management programs shall continue to be important service components delivered as a portion of the medicaid benefit package. [~~The case management programs are defined in 8.326.2 NMAC through 8.326.6 NMAC and 8.320.5 NMAC.~~]

[8.305.9.9 NMAC - Rp 8.305.9.9 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.9.10 COORDINATION OF PHYSICAL AND BEHAVIORAL HEALTH SERVICES BENEFITS:

A. **Coordination of physical and behavioral health services:** Physical and behavioral health services shall be provided through a clinically coordinated system between the MCO and SE. The MCO and SE shall coordinate a member's care with one another, if the member has both physical and behavioral health needs. Both physical and behavioral health care providers would benefit from having access to relevant medical records of mutually-served members to ensure the maximum benefit of services to the member. The MCO and the SE shall develop and share policies and procedures to ensure effective care coordination across systems as authorized by the member. Both contractors shall be responsible for monitoring the effectiveness of referrals and coordinating with multiple providers and for the process of information sharing between the physical and behavioral health care providers. The MCO/SE shall have defined processes for coordinating complex physical and behavioral health cases, which include participation of its medical directors. Confidentiality and HIPAA regulations apply during this coordination process.

B. **Coordination mechanisms:** The MCO/SE shall work proactively to achieve appropriate coordination between physical and behavioral health services by implementing complimentary policies and procedures for the coordination of services. The MCO/SE shall implement policies and procedures that maximize care coordination to access medicaid services external to the MCO's program, such as home and community-based waiver programs, the medicaid school-based services (MSBS) program and the children's medical services (CMS). The MCO/SE shall have procedures that ensure PCPs consistently receive communication, with the member's written consent, regarding member status and follow-up care by a specialist provider. The MCO/SE shall provide comprehensive education to its provider networks regarding HIPAA compliant protocols for sharing information between physical health, behavioral health and other providers.

C. **Referrals for behavioral health services:** The MCO shall educate and assist the PCPs regarding proper procedures for making appropriate referrals for behavioral health consultation and treatment through the SE.

D. **Referrals for physical health services:** The SE shall educate and assist the behavioral health providers regarding proper procedures for making appropriate referrals for physical health consultation and treatment when accessing needed physical health services. The SE shall coordinate care with primary care providers, with the member's written consent.

E. **Referral policies and procedures:** The MCO/SE shall offer statewide trainings to all providers regarding its specific referral policies and procedures. [~~The MCO/SE referral policies and procedures shall also be provided in provider manuals distributed to all contracted providers.~~] The MCO/SE shall develop and implement policies and procedures that encourage PCPs to refer members to the SE for behavioral health services or directly to behavioral health service providers in an appropriate and timely manner, with the member's documented permission. These referral policies and procedures shall be provided in provider manuals distributed to all contracted providers. A member may access behavioral health services through direct contact with the SE or by going directly to a behavioral health provider. A written report of the behavioral health service containing sufficient information to coordinate the member's care shall be forwarded to the PCP by the behavioral health provider with the member's written consent with oversight from the SE within [~~7~~] seven calendar days after screening and evaluation.

F. **Indicators for PCP referral to behavioral health services:** The following are common indicators for a referral to the SE for behavioral health services or for a referral directly to a behavioral health provider by a PCP:

(1) suicidal/homicidal ideation or behavior;

(2) at-risk of hospitalization due to a behavioral health condition;

(3) children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital, residential treatment facility, or treatment foster care placement;

(4) trauma victims including possible abused or neglected members;

(5) serious threat of physical or sexual abuse or risk to life or health due to impaired mental status and judgment, mental retardation, or other developmental disabilities;

(6) request by member, parent or legal guardian of a minor for behavioral health services;

(7) clinical status that suggests the need for behavioral health services;

(8) identified psychosocial stressors and precipitants;

(9) treatment compliance complicated by behavioral characteristics;

(10) behavioral, psychiatric or substance abuse factors influencing a medical condition;

(11) victims or perpetrators of abuse and neglect;

(12) non-medical management of substance abuse;

(13) follow-up to medical detoxification;

(14) an initial PCP contact or routine physical examination indicates a substance abuse or mental health problem;

(15) a prenatal visit indicates a substance abuse or mental health problem;

(16) positive response to questions indicates substance abuse, observation of clinical indicators or laboratory values that indicate substance abuse;

(17) a pattern of inappropriate use of medical, surgical, trauma, urgent care or emergency room services that could be related to substance abuse or other behavioral health conditions; and

(18) the persistence of serious functional impairment.

G. **Referrals for physical health or behavioral health consultation and treatment:** The SE shall educate and assist behavioral health providers to make appropriate referrals for physical health consultation and treatment to the medicaid member's PCP or MCO as authorized by the member. The MCO shall educate and assist the physical health providers to make appropriate referrals for behavioral health consultation and treatment.

H. **Independent access:** The MCO/SE shall develop and implement policies and procedures that allow members access to behavioral health services through the SE directly and without referral from the PCP. These policies and procedures shall require timely access to behavioral health services.

I. **Behavioral health plan:** The behavioral health provider designated as the "clinical home" shall take responsibility for developing and implementing the member's behavioral health treatment plan in coordination with the member, parent or legal guardian and other providers, when clinically indicated. With the member's documented permission, multiple behavioral health providers shall coordinate their treatment plans and progress information to provide optimum care for the member. Community case managers shall be responsible for monitoring the treatment plan and coordinating treatment team meetings for members receiving behavioral health care from multiple providers.

J. **On-going reporting:**

(1) The SE shall require that a behavioral health provider must keep the member's PCP informed, with the member's written consent, of the following:

(a) drug therapy;

(b) laboratory and radiology results;

(c) sentinel events such as hospitalization, emergencies, and incarceration;

(d) discharge from a psychiatric hospital, residential treatment services, treatment foster care placement or from other behavioral health services; and

(e) all transitions in level of care.

(2) The MCO shall require that a PCP must keep the member's behavioral health provider informed, with the member's written consent, of the following:

(a) drug therapy;

(b) laboratory and radiology results;

(c) medical consultations; and

(d) sentinel events such as hospitalization and emergencies.

K. **Psychiatric consultation:** The PCP and all behavioral health providers are encouraged to obtain consultations and assistance with psychopharmacotherapy and diagnostic evaluations from an SE contracted psychiatrist or other behavioral health specialist with prescribing authority, when clinically appropriate.

[8.305.9.10 NMAC - Rp 8.305.9.10 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.9.11 COORDINATION WITH WAIVER PROGRAMS: The MCO/SE shall have policies and procedures governing coordination of services with home and community-based medicaid waiver programs to assist with complex care coordination. The MCO/SE shall coordinate care with the member's waiver case manager or the mi via consultant to ensure that medical information is shared, following HIPAA guidelines, and that medically necessary services are provided and are not duplicated. HSD shall monitor utilization of services by waiver recipients to ensure that the MCO/SE provides to members who are waiver participants all benefits included in the medicaid benefit package.

[8.305.9.11 NMAC - Rp 8.305.9.11 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.10 NMAC, Sections 8, 11 and 12, which will be effective July 1, 2009.

8.305.10.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost-effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.

[8.305.10.8 NMAC - N, 7-1-01; A, 7-1-09]

8.305.10.11 ENCOUNTER SUBMISSION TIME FRAMES: The MCOs/SE shall submit encounter data to HSD within 120 days of the service delivery date, payment date or discharge as defined by HSD. HSD shall establish error thresholds, time frames and procedures for the submission, correction and resubmission of encounter data.

[8.305.10.11 NMAC - Rp 8 NMAC 4.MAD.606.9.2, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-09]

8.305.10.12 ENCOUNTER DATA ELEMENTS: Encounter data elements are a combination of those elements required by HIPAA-compliant transaction formats, which comprise a minimum core data set for states and MCOs/SE and those required by CMS[~~,~~] or HSD [~~or the collaborative~~] for use in managed care. Encounter data elements are specified in the medicaid systems manual. HSD may increase or reduce or make mandatory or optional, data elements as it deems necessary.

[8.305.10.12 NMAC - Rp 8 NMAC 4.MAD.606.9.3, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.11 NMAC, Sections 8 and 9, which will be effective July 1, 2009.

8.305.11.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost-effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.
[8.305.11.8 NMAC – N, 7-1-01; A, 7-1-09]

8.305.11.9 REIMBURSEMENT FOR MANAGED CARE:

A. **Payment for services:** HSD shall make actuarially sound payments under capitated risk contracts to the designated MCO/SE. Rates, whether set by HSD, or negotiated between HSD and the MCO/SE are considered confidential. Rates shall be appropriate for the medicaid populations to be covered and the services to be furnished under the contract. The MCO/SE shall be responsible for the provision of services for members during the month of capitation. Medicaid members shall not be liable for debts incurred by an MCO/SE under the MCO's or SE's managed care contract for providing health care to medicaid members. This shall include, but not be limited to:

(1) the MCO's/SE's debts in the event of the MCO's/SE's insolvency;

(2) services provided to the member, that are not included in the medicaid benefit package and for which HSD does not pay the MCO/SE, e.g., value added services;

(3) when the MCO/SE does not pay the health care provider that furnishes the services under contractual, referral, or other arrangement;

(4) payments for covered services furnished under contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the MCO/SE provided the service directly; and

(5) if an MCO/SE member loses eligibility for any reason and is reinstated as eligible by HSD before the end of the month, the MCO/SE shall accept a retro capitation payment for that month of eligibility and assume financial responsibility for all medically necessary covered benefit services supplied to the member.

B. **Capitation disbursement requirements:** HSD shall pay a capitated amount to the MCO/SE for the provision of the managed care benefit package at specified rates. The monthly rate is based on actuarially sound capitation rate cells. The MCO/SE shall accept the capitation rate paid each month by HSD as payment in full for all services to be provided pursuant to the agreement, including all administrative costs associated therewith. HSD/MAD will calculate or verify the MCO/SE's income at the end of the state fiscal year to determine if the extent was expended on the services required under the contract utilizing reported information and the department of insurance reports. Administrative costs, to be no higher than the allowable percent, including all MCO/SE-delegated entities (if applicable), and other financial information will be monitored. The MCO/SE does not have the option of deleting benefits from the medicaid defined benefit package. Should the MCO/SE not meet the required administrative or direct services costs within the terms of the contract, sanctions or financial penalties may be imposed.

C. **Payment time frames:** Clean claims as defined in Subsection L of 8.305.1.7 NMAC, *Clean Claim*, shall be paid by the MCO/SE to contracted and noncontracted providers according to the following timeframe: 90 percent within 30 days of the date of receipt and 99 percent within 90 days of the date of receipt, as required by federal guidelines in the Code of Federal Regulations, Section 42 CFR 447.45. The date of receipt is the date the MCO/SE first receives the claim either manually or electronically. The MCO/SE is required to date stamp all claims on the date of receipt. The date of payment is the date of the check or other form of payment. An exception to this rule may be made if the MCO/SE and its providers, by mutual agreement, establish an alternative payment schedule. However, any such alternative payment schedule shall first be incorporated into the contract between HSD and the MCO/SE. The MCO/SE shall be financially responsible for paying all claims for all covered emergency and post-stabilization services that are furnished by non-contracted providers, at no more than the fee-for-service rate, including medically or clinically necessary testing to determine if a physical or behavioral health emergency exists.

(1) An MCO/SE shall pay contracted and noncontracted providers interest on the MCO's/SE's liability at the rate of [~~1 1/2~~] one and one-half percent per month on the amount of a clean claim (based upon the current medicaid fee schedule) submitted by the participating provider and not paid within 30 days of the date of receipt of an electronic claim and 45 days of receipt of a manual claim. Interest shall accrue from the 31st day for electronic claims and from the 46th day for manual claims. The MCO/SE shall be required to report the number of claims and the amount of interest paid, on a timeframe determined by HSD/MAD.

(2) No contract between the MCO/SE and a participating provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions.

(3) If the MCO/SE is unable to determine liability for, or refuses to pay, a claim of a participating provider within the times specified above, the MCO/SE shall make a good-faith effort to notify the participating provider by fax, electronic or other written communication within 30 days of receipt of the claim, stating specific reasons why it is not liable for the claim or request specific information necessary to determine liability for the claim.

D. **Rate setting:** Capitation rates paid by HSD to the MCO/SE for the provision of the managed care medicaid benefit package shall be calculated through actuarial analysis, be actuarially sound and meet the standards set by 42 CFR 438.6(c).

E. **Payment on risk basis:** The MCO/SE is at risk of incurring losses if its costs of providing the managed care medicaid benefit package exceed its capitation payment. HSD shall not provide retroactive payment adjustments to the MCO/SE to reflect the actual cost of services furnished by the MCO/SE.

F. **Change in capitation rates:** HSD shall review the capitation rates 12 months from the effective date of the contract and annually thereafter. HSD may adjust the capitation rates based on factors such as the following: changes in the scope of work; CMS requiring a modification of the state's waiver; if new or amended federal or state laws or regulations are implemented; inflation; or if significant changes in the demographic characteristics of the member population occur.

G. **Solvency requirements and risk protections:** An MCO/SE that contracts with HSD to provide medicaid physical or behavioral health services shall comply with, and be subject to, all applicable state and federal laws and regulations, including solvency and risk standards. In addition to requirements imposed by state and federal law, the MCO/SE shall be required to meet specific medicaid financial requirements and to provide to HSD the information and records necessary to determine the MCO's/SE's financial condition. Requests for information and records shall be delivered to HSD, at no cost to HSD, in a reasonable time after the date of request or as specified in the contract.

(1) **Reinsurance:** An [~~MCO~~] MCO/SE participating in medicaid managed care shall purchase reinsurance at a

minimum of $1,000,000.00 in reinsurance protection against financial loss due to outlier (catastrophic) cases. The MCO shall document for HSD that reinsurance is in effect through the term of the contract and that the amount of reinsurance is sufficient to cover probable outlier cases or overall member utilization at an amount greater than expected. Pursuant to 42 CFR 438.6(e)(5), contract provisions for reinsurance, stop-loss limits, or other risk sharing methodologies shall be computed on an actuarially sound basis.

(2) **Third party liability (TPL):** The MCO/SE shall be responsible for identifying a member's third party coverage and coordinating of benefits with third parties as required by federal law. The MCO/SE shall inform HSD when a member has other health care insurance coverage. The MCO shall have the sole right of subrogration, for 12 months, from when the MCO incurred the cost on behalf of the members, to initiate recovery or to attempt to recover any third-party resources available to medicaid members and shall make records pertaining to third party collections (TPL) for members available to HSD/MAD for audit and review. If the MCO has not initiated recovery or attempted to recover any third-party resources available to medicaid members within 12 months, HSD will pursue the member's third party resources. The MCO/SE shall provide to HSD for audit and review all records pertaining to TPL collections for members.

(3) **Fidelity bond requirement:** The MCO/SE shall maintain a fidelity bond in the maximum amount specified under the Insurance Code.

(4) **Net worth requirement:** The MCO/SE shall comply with the net worth requirements of the Insurance Code.

(5) **Solvency cash reserve requirement:** The MCO/SE shall have sufficient reserve funds available to ensure that the provision of services to medicaid members is not at risk in the event of MCO/SE insolvency.

(6) **Per enrollee cash reserve:** The MCO/SE shall maintain three percent of the monthly capitation payments per member with an independent trustee during each month of the agreement. [~~If the agreement replaces a previous agreement with HSD/MAD to provide Medicaid managed care, then continued maintenance of the per member cash reserve established and maintained by the MCO/SE pursuant to such previous agreement shall be deemed to satisfy this requirement~~.] HSD shall adjust this cash reserve requirement annually, or as needed, based on the number of the MCO's/SE's members, or the failure of the MCO/SE to maintain the required cash reserve, and shall notify the MCO/SE of the cash reserve requirement. Each MCO/SE shall maintain its own cash reserve account. This account may be accessed solely for payment for services to the MCO's/SE's members in the event that the MCO/SE becomes insolvent. Money in the reserve account remains the property of the MCO/SE, and any interest earned (even if retained in the account) shall be the property of the MCO/SE. Failure to maintain the reserve as directed above will result in financial penalties equal to 25 percent of the amount of shortfall in the account each month. If the cash reserve account exceeds 105 percent of an amount equal to three percent of the annualized capitation as determined above, for more than two months, HSD will direct the MCO/SE to reduce the reserve to the 100 percent level and the MCO/SE shall comply with such direction within 30 days.

H. **Inspection and audit for solvency requirements:** The MCO/SE shall meet all requirements for state licensure with respect to inspection and auditing of financial records. The MCO/SE shall provide to HSD or its designee all financial records required by HSD. HSD, or its designees may inspect and audit the MCO's/SE's financial records at least annually or at HSD discretion.

I. **Special payment requirements:** This section lists special payment requirements by provider type.

(1) **Reimbursement for FQHCs:** Under federal law, FQHCs shall be reimbursed at 100 percent of reasonable cost under a medicaid fee-for-service or managed care program. The FQHC may waive its right to 100 percent of reasonable cost and elect to receive a rate negotiated with the MCO/SE. HSD shall provide a discounted wrap-around payment to FQHCs that have waived a right to 100 percent reimbursement of reasonable cost from the MCO/SE.

(2) **Reimbursement for providers furnishing care to Native Americans:** If an Indian health service (IHS) or tribal 638 provider delivers services to an MCO/SE member who is Native American, the MCO/SE shall reimburse the provider at the rate established by the office of management and budget (OMB) for specified services for the [~~IHS facilities except as otherwise specified in writing by HSD~~] IHS and tribal 638 facilities and providers. Pharmacy, inpatient physician services, case management, vision appliances, nutritional services and ambulatory surgical center services shall be paid at the fee schedule rate established by HSD. With the exception of residential treatment center services, services provided at Indian health service and tribal 638 facilities are not subject to prior authorization.

(3) **Reimbursement for family planning services:** The MCOs shall reimburse out-of-network family planning providers for services provided to MCO members at a rate at least equal to the medicaid fee-for-service rate for the provider type.

(4) **Reimbursement for women in the third trimester of pregnancy:** If a woman in the third trimester of pregnancy at the time of her enrollment in managed care has an established relationship with an obstetrical provider and desires to continue that relationship and the provider is not contracted with the MCO, the MCO shall reimburse the out-of-network provider for care directly related to the pregnancy, including delivery and a six-week post-partum visit.

(5) **Reimbursement for members who disenroll while hospitalized:** [~~If a medicaid member is hospitalized at the time of disenrollment, the organization MCO/SE or FFS exempt, which was originally responsible for the hospital inpatient placement, shall remain financially responsible for payment of all covered inpatient facility and professional services from the date of admission to the date of discharge, or upon transfer to a lower level of care. Upon discharge, the member will then become the financial responsibility of the organization receiving capitation payments.~~] Regarding Salud! MCO and medicaid fee-for-service (FFS) members: if an MCO or FFS member is hospitalized at the time of enrollment into or disenrollment from managed care or upon an approved switch from one MCO to another, the originating MCO shall be responsible for payment of all covered inpatient facility and professional services provided within a licensed acute care facility, or a non-psychiatric specialty unit or hospitals as designated by the New Mexico department of health. The payer at the date of admission remains responsible for the services until the date of discharge. Upon discharge, the member will then become the financial responsibility of the organization or entity receiving capitation payments or FFS in the case of disenrollment from Salud! Regarding Salud! MCO and CoLTS MCO members: for members transitioning to or from CoLTS, the originating MCO shall be responsible for payment of all covered inpatient facility and professional services up to the date of disenrollment from Salud! to CoLTS or disenrollment from CoLTS to Salud! For either transition, services provided at a free-standing psychiatric hospital or within a psychiatric unit of an acute care hospital are the responsibility of the SE.

(6) **Sanctions for noncompliance:** The department may impose financial penalties or sanctions against an MCO/SE that fails to meet the financial

requirements specified in this section or additional requirements specified in the terms of the medicaid managed care contract or federal medicaid law.

J. **Recoupment payments:** HSD shall recoup payments for MCO members who are incorrectly enrolled with more than one MCO, including members categorized as newborns or X5; payments made for MCO/SE members who die prior to the enrollment month for which payment was made; or payments to the MCO/SE for members whom HSD later determines were not eligible for medicaid during the enrollment month for which payment was made. Any duplicate payment identified by either the MCO/SE or HSD shall be recouped upon identification. In the event of an error, which causes payment(s) to the MCO/SE to be issued by HSD, HSD shall recoup the full amount of the payment. Interest shall accrue at the statutory rate on any amounts not paid and determined to be due after the 30th day following the notice. Any process that automates the recoupment procedures shall be discussed in advance by HSD and the MCO/SE and documented in writing, prior to implementation of the new automated recoupment process. The MCO/SE has the right to dispute any recoupment action in accordance with contractual provisions.

K. HSD shall pay interest at [~~9~~] nine percent per annum on any capitation payment due to the MCO/SE that is more than 30 days late. No interest or penalty shall accrue for any other late payments or reimbursements.

L. HSD may initiate alternate payment methodology for specified program services or responsibilities.

[8.305.11.9 NMAC - Rp 8 NMAC 4.MAD.606.10, 7-1-01; A, 7-1-04; A, 7/1/05; A, 9-1-06; A, 7-1-07; A, 7-1-08; A, 7-16-08; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.12 NMAC, Sections 8, 10 and 12, which will be effective July 1, 2009.

8.305.12.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost-effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.

[8.305.12.8 NMAC - Rp 8.305.12.8 NMAC, 7-1-04; A, 7-1-09]

8.305.12.10 GENERAL REQUIREMENTS FOR GRIEVANCE AND APPEALS:

A. The MCO/SE shall have a grievance system in place for members that [~~includes~~] include a grievance process related to dissatisfaction and an appeals process related to an MCO/SE action, including the opportunity to request an HSD fair hearing.

B. The MCO/SE shall implement written policies and procedures describing how the member may submit a request for a grievance or an appeal with the MCO/SE or submit a request for a fair hearing with HSD. The policy shall include a description of how the MCO/SE resolves the grievance or appeal.

C. The MCO/SE shall provide to all service providers in the MCO/SE's network a written description of the MCO/SE's grievance and appeal process and how the provider can submit a grievance or appeal.

D. The MCO/SE shall have available reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

E. The MCO/SE shall name a specific individual(s) designated as the MCO/SE's medicaid member grievance or appeal coordinator with the authority to administer the policies and procedures for resolution of a grievance or an appeal, to review patterns/trends in grievances or appeals, and to initiate corrective action.

F. The MCO/SE shall ensure that the individuals who make decisions on grievances or appeals are not involved in any previous level of review or decision-making. The MCO/SE shall also ensure that health care professionals with appropriate clinical expertise shall make decisions for the following:

(1) an appeal of an MCO/SE denial that is based on lack of medical necessity;

(2) an MCO/SE denial that is upheld in an expedited resolution; and

(3) a grievance or appeal that involves clinical issues.

G. Upon enrollment, the MCO/SE shall provide members, at no cost, with a member information sheet or handbook that provides information on how they or their representative(s) can file a grievance or an appeal, and the resolution process. The member information shall also advise members of their right to file a request for an administrative hearing with the HSD hearings bureau, upon notification of an MCO/SE action, or concurrent with, subsequent to or in lieu of an appeal of the MCO/SE action. The information shall meet the standards specified in Paragraph (15) of Subsection C of 8.305.8.15 NMAC.

H. The MCO/SE shall ensure that punitive or retaliatory action is not taken against a member or a provider that files a grievance or an appeal, or a provider that supports a member's grievance or appeal.

[8.305.12.10 NMAC - Rp 8.305.12.10 & 11 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.12.12 APPEALS: An appeal is a request for review by the MCO/SE of an MCO/SE action.

A. An action is defined as:

(1) the denial or limited authorization of a requested service, including the type or level of service;

(2) the reduction, suspension, or termination of a previously authorized service;

(3) the denial, in whole or in part, of payment for a service;

(4) the failure of the MCO/SE to provide services in a timely manner, as defined by HSD; or

(5) the failure of the MCO/SE to complete the authorization request in a timely manner as defined in 42 CFR 438.408.

B. **Notice of MCO/SE action:** The MCO/SE shall mail a notice of action to the member or provider within 10 days of the date of the action for previously authorized services as permitted under 42 CFR 431.213 and 431.214 and within 14 days of the action for newly requested services. Denials of claims that may result in member financial liability require immediate notification. The notice shall contain, but not be limited to, the following:

(1) the action the MCO/SE has taken or intends to take;

(2) the reasons for the action;

(3) the member's or the provider's right, as applicable, to file an appeal of the MCO/SE action through the MCO/SE;

(4) the member's right to request an HSD fair hearing and what the process would be;

(5) the procedures for exercising the rights specified;

(6) the circumstances under which expedited resolution of an appeal is available and how to request it;

(7) the member's right to have benefits continue pending resolution of an appeal or fair hearing, how to request the continuation of benefits, and the circumstances under which the member may be required to pay the costs of continuing these benefits.

C. A member may file an appeal of an MCO/SE action within 90 calendar days of receiving the MCO/SE's

notice of action. The legal guardian of the member for a minor or an incapacitated adult, a representative of the member as designated in writing to the MCO/SE, or a provider acting on behalf of the member with the member's written consent, have the right to file an appeal of an action on behalf of the member. The MCO/SE shall consider the member, representative, or estate representative of a deceased member as parties to the appeal.

D. The MCO/SE has 30 calendar days from the date the initial oral or written appeal is received by the MCO/SE to resolve the appeal. The MCO/SE shall appoint at least one person to review the appeal who is qualified to make the decision and was not involved in the initial decision [~~and who is not the subordinate of any person involved in the initial decision~~].

E. The MCO/SE shall have a process in place that ensures that an oral or written inquiry from a member seeking to appeal an action is treated as an appeal (to establish the earliest possible filing date for the appeal). An oral appeal shall be followed by a written appeal within 10 calendar days that is signed by the member. The MCO/SE shall use its best efforts to assist members as needed with the written appeal and may continue to process the appeal.

F. Within five working days of receipt of the appeal, the MCO/SE shall provide the grievant with written notice that the appeal has been received and the expected date of its resolution. The MCO/SE shall confirm in writing receipt of oral appeals, unless the member or the provider requests an expedited resolution.

G. The MCO/SE may extend the 30-day timeframe by 14 calendar days if the member requests the extension, or the MCO/SE demonstrates to HSD that there is need for additional information, and the extension is in the member's interest. For any extension not requested by the member, the MCO/SE shall give the member written notice of the extension and the reason for the extension within two working days of the decision to extend the timeframe.

H. The MCO/SE shall provide the member or the member's representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing.

I. The MCO/SE shall provide the member or the representative the opportunity, before and during the appeals process, to examine the member's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the appeals process. The MCO/SE shall include as parties to the appeal the member and his or her representative, or the legal representative of a deceased member's estate.

J. For all appeals, the MCO/SE shall provide written notice within the 30-calendar-day timeframe for resolutions to the member or the provider, if the provider filed the appeal.

(1) The written notice of the appeal resolution shall include, but not be limited to, the following information:

(a) the results of the appeal resolution; and

(b) the date it was completed.

(2) The written notice of the appeal resolution for appeals not resolved wholly in favor of the member shall include, but not be limited to, the following information:

(a) the right to request an HSD fair hearing and how to do so;

(b) the right to request receipt of benefits while the hearing is pending, and how to make the request; and

(c) that the member may be held liable for the cost of continuing benefits if the hearing decision upholds the MCO/SE's action.

K. The MCO/SE may continue benefits while the appeal or the HSD fair hearing process is pending.

(1) The MCO/SE shall continue the member's benefits if all of the following are met:

(a) the member or the provider files a timely appeal of the MCO/SE action or the member asks for a fair hearing within 13 days from the date on the MCO/SE notice of action;

(b) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(c) the services were ordered by an authorized provider;

(d) the time period covered by the original authorization has not expired; and

(e) the member requests extension of the benefits.

(2) The MCO/SE shall provide benefits until one of the following occurs:

(a) the member withdraws the appeal;

(b) 13 days have passed since the date of the resolution letter, provided the resolution of the appeal was against the member and the member has taken no further action;

(c) HSD issues a hearing decision adverse to the member; and

(d) the time period or service limits of a previously authorized service has expired.

(3) If the final resolution of the appeal is adverse to the member, that is, the MCO/SE's action is upheld, the MCO/SE may recover the cost of the services furnished to the member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b).

(4) If the MCO/SE or HSD reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending, the MCO/SE shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

(5) If the MCO/SE or HSD reverses a decision to deny, limit or delay services and the member received the disputed services while the appeal was pending, the MCO/SE shall pay for these services.

[8.305.12.12 NMAC - Rp 8.305.12.12 NMAC, 7-1-04; A. 7-1-05; A, 9-1-06; A, 7-1-07, A, 7-1-08; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.13 NMAC, Sections 8 and 10, which will be effective July 1, 2009.

8.305.13.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost-effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.

[8.305.13.8 NMAC - N, 7-1-01; A, 7-1-09]

8.305.13.10 MANAGED CARE ORGANIZATION AND SINGLE STATEWIDE ENTITY REQUIREMENTS: The MCO/SE shall have in place internal controls, policies and procedures for the prevention, detection, investigation and reporting of potential fraud and abuse activities concerning providers and members. The MCO/SE specific internal controls, policies and procedures shall be described in a comprehensive written plan submitted to HSD, or its designee, for approval. Substantive amendments or modifications to the plan shall be approved by HSD. The MCO/SE shall maintain procedures for reporting potential and actual fraud and abuse by clients or providers to HSD. The MCO/SE shall:

A. have internal procedures that facilitate preliminary investigating and reporting of potential and actual fraud and abuse to HSD, or its designee, for further investigation;

B. have specific controls

in place for prevention and detection of potential cases of fraud and abuse, such as claims edits, post processing review of claims, provider profiling/exception reporting and credentialing prior authorizations, utilization/quality management monitoring;

C. have a mechanism to work with HSD, or its designee, to further develop prevention and detection methods and best practices and to monitor outcomes for medicaid managed care;

D. have internal procedures to prevent, detect and investigate program violations to recover funds misspent due to fraudulent or abusive actions;

E. report to HSD the names of all providers identified with aberrant utilization, according to provider profiles, regardless of the cause of the aberrancy;

F. report to HSD any administrative action taken to limit the ability of an individual or entity to participate in the program;

G. report to HSD any individual or entity that has been excluded from providing items or services to medicaid members;

[~~F.~~] H. designate a compliance officer and a compliance committee who are accountable to senior management;

[~~G.~~] I. provide effective fraud and abuse detection training, administrative remedies for false claims and statements and whistleblower protection under such laws to the MCO/SE's employees that includes:

(1) written policies for all employees, agents or contractors that provide detailed information regarding the New Mexico Medicaid False Claims Act, NMSA 1978, and the federal False Claims Act established under sections 3729 through 3733 of Title 31, United States Code, administrative remedies for false claims and statements established under Chapter 38 of Title 31, United States code, including but not limited to, preventing and detecting fraud, waste and abuse in federal health care programs (as defined in section 1128B (f) of the Social Security Act);

(2) include as part of such written policies, detailed provision regarding the MCO/SE's policies and procedures for detecting and preventing fraud, waste and abuse; and

(3) include in any employee handbook, a specific discussion of the laws described in Paragraph (1) above, the rights of employees to be protected as whistleblowers, and the contractor's or subcontractor's policies and procedures for detecting and preventing fraud, waste and abuse;

[~~H.~~] J. implement effective lines of communication between the compliance officer and the MCO/SE's employees;

[~~I.~~] K. require enforcement of standards through well-publicized disciplinary guidelines; and

[~~J.~~] L. have a provision for prompt response to detected offenses and for development of corrective action initiatives relating to the MCO/SE's contract.

[8.305.13.10 NMAC - Rp 8 NMAC 4.MAD.606.12.1, 7-1-01; A, 7-1-05; A, 7-1-07; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.14 NMAC, Sections 8 and 10, which will be effective July 1, 2009.

8.305.14.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost-effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.

[8.305.14.8 NMAC - N, 7-1-01; A, 7-1-09]

8.305.14.10 REPORTING STANDARDS:

A. Reports submitted by the MCO/SE to HSD shall meet certain standards.

(1) The MCO/SE shall verify the accuracy of data and other information on reports submitted. The MCO/SE shall send a written data certification for all financial reports. The data shall be certified by the MCO/SE's: 1) chief executive officer; 2) chief financial officer; or 3) an individual who has delegated authority to sign for, and who reports directly to, the MCO/SE's chief executive officer or chief financial officer. The certification shall attest, based on best knowledge, information and beliefs as to the accuracy, completeness and truthfulness of the documents and data. The MCO/SE shall submit the certification concurrently with the certified data and documents.

(2) Reports or other required data shall be received on or before scheduled due dates.

(3) Reports or other required data shall conform to HSD's defined standards as specified in writing.

(4) All required information shall be fully disclosed in a manner that is responsive and with no material omission.

(5) The MCO/SE shall analyze all required reports internally before submitting them to HSD. The MCO/SE shall analyze the report for any early patterns of change, identified trend, or outlier (catastrophic case), and shall submit this analysis with the required report. The MCO/SE shall send a written narrative for specified reports with the report documenting the MCO/SE's interpretation of the early pattern of change, identified trend, or outlier.

B. **Consequences of violation of reporting standards:** The submission of late, inaccurate or otherwise incomplete reports shall be considered failure to report. Sanctions may be imposed by HSD, or its designee on the MCO/SE for failure to submit accurate and timely reports.

C. **Changes in requirements:** HSD's requirements regarding reports, report content and frequency of submission may change during the term of the contract. The MCO/SE shall comply with changes specified by HSD.

[8.305.14.10 NMAC - Rp 8 NMAC 4.MAD.606.13.1, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.15 NMAC, Sections 8, 9, 11, 14 and 15, which will be effective July 1, 2009.

8.305.15.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost-effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.

[8.305.15.8 NMAC - Rp 8.305.15.8 NMAC, 7-1-04; A, 7-1-09]

8.305.15.9 SERVICES FOR INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS (ISHCN):

A. ISHCN require a broad range of primary, specialized medical, behavioral health and related services. ISHCN are individuals who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition [~~, or low to severe functional limitation,~~] and who [~~also~~] require health and related services of a type or amount beyond that required by other individuals. ISHCN have ongoing health conditions, high or complex service utilization, and low to severe functional limitations. The primary purpose of the definition is to identify these individuals so that the MCO/SE can facilitate access to appropriate services. The definition also allows for flexible targeting of individuals based on clinical justification and discontinuing targeted efforts when such efforts are no longer needed.

B. **Identification of**

enrolled ISHCN: The MCO/SE shall have written policies and procedures in place with HSD's approval, which govern how members with multiple and complex physical and behavioral health care needs shall be identified. The MCO/SE shall have an internal operational process, in accordance with policy and procedure, to target members for the purpose of applying stratification criteria to identify [~~ISHCNs~~] ISHCN. The MCO/SE shall employ reasonable effort to identify [~~ISHCNs~~] ISHCN based at least on the following criteria:

(1) individuals eligible for SSI;

(2) individuals enrolled in the home-based waiver programs;

(3) children receiving foster care or adoption assistance support;

(4) individuals identified by service utilization, clinical assessment, or diagnosis; and

(5) [~~referral~~] individuals referred by family or a public or community program.

[8.305.15.9 NMAC - Rp 8.305.15.9 NMAC, 7-1-04; A, 7-1-05; A, 7-1-09]

8.305.15.11 CHOICE OF SPECIALIST AS PCP: The MCO shall develop and implement policies and procedures governing the process for member selection of a PCP, including the right by an ISHCN to choose a specialist as a PCP. The specialist provider must agree to [~~be the PCP~~] provide all mandated PCP services. See 8.305.6.12 NMAC, *Primary Care Providers.*

[8.305.15.11 NMAC - Rp 8.305.15.11 NMAC, 7-1-04; A, 7-1-09]

8.305.15.14 CARE COORDINATION FOR ISHCN: The [~~MCOs/SE~~] MCO/SE shall develop policies and procedures to provide care coordination for ISHCN. Please refer to Section 8.305.9.9 NMAC, *Coordination of Services*, for definition.

A. The MCO/SE shall have an internal operational process, in accordance with policy and procedure, to target medicaid members for purposes of applying stratification criteria to identify those who are potential ISHCN. The contractor shall provide HSD with the applicable policy and procedure describing the targeting and stratification process.

B. The MCO/SE shall have written policies and procedures to ensure that each member identified as having special health care needs is assessed by an appropriate health care professional regarding the need for care coordination. If the member has both physical and behavioral health special needs, the MCO and SE shall coordinate care in a timely collaborative manner.

C. The MCO/SE shall have written policies and procedures for educating ISHCN [~~needs~~] and, in the case of children with special health care needs, parent(s)[~~,~~] or legal guardians, that care coordination is available and when it may be appropriate to their needs.

[8.305.15.14 NMAC - Rp 8.305.15.14 NMAC, 7-1-04; A, 7-1-05; A, 7-1-09]

8.305.15.15 EMERGENCY, INPATIENT AND OUTPATIENT AMBULATORY SURGERY HOSPITAL REQUIREMENTS FOR ISHCN: The MCO/SE shall develop and implement policies and procedures for:

A. educating the ISHCN, the ISHCN's family members [~~and/or~~] or caregivers concerning [~~the ISHCNs~~] ISHCN with complicated clinical histories on how to access emergency room care and what clinical history to provide when emergency care or inpatient admission is needed, including behavioral health emergency care;

B. how coordination with the PCP, the SE (if applicable) and the hospitalist shall occur when an ISHCN is hospitalized;

C. ensuring that the emergency room physician has access to the individual's medical [~~and/or~~] or behavioral health clinical history; and

D. obtaining any necessary referrals from PCPs for inpatient hospital staff providing outpatient or ambulatory surgical procedures.

[8.305.15.15 NMAC - Rp 8.305.15.15 NMAC, 7-1-04; A, 7-1-05; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.16 NMAC, Sections 8 and 9, which will be effective July 1, 2009.

8.305.16.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost-effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.

[8.305.16.8 NMAC - N, 7-1-01; A, 7-1-09]

8.305.16.9 MEMBER TRANSITION OF CARE: Transition of care refers to the movement of members from one health care practitioner or setting to another as their condition and care needs change. The MCO/SE shall have the resources and policies and procedures in place to [~~ensure continuity of care without disruption in service to members and to assure the service provider of payment. The MCO/SE shall actively assist members, in particular ISHCN~~] actively assist members with transition of care. Members transitioning from institutional levels of care such as hospitals, nursing homes, residential treatment facilities or [~~ICF/MRs~~] ICFs/MR back to community services with transition of care needs shall be [~~offered~~] provided with care coordination services [~~as indicated~~]. Medicaid-eligible clients may initially receive physical and behavioral health services under fee-for-service medicaid prior to enrollment in managed care. During the member's medicaid eligibility period, enrollment status with a particular MCO may change and the member may switch enrollment to a different MCO. Certain members covered under managed care may become exempt and other members may lose their medicaid eligibility while enrolled in an MCO/SE. A member changing from MCO to MCO, fee-for-service to managed care coverage and vice versa shall continue to receive medically necessary services in an uninterrupted manner.

A. **Member transition:** The MCO/SE shall have policies and procedures that address member identification and the clinical transition and transfer of members into or out of the MCO, including the [~~CLTS~~] CoLTS MCO.

(1) The MCO shall have policies and procedures that cover potentially large or mass transfer of members into or out of the MCO, including the identification of members currently receiving services, and the SE shall be notified.

(2) The MCO shall have policies and procedures covering the transition into the MCO of an individual member, which shall include member and provider education about the MCO, about self-care and the optimization of treatment, and the review and update of existing courses of treatment. The SE shall be notified and coordination of care shall occur.

(3) The MCO shall have policies and procedures that identify members transferring out of the MCO and ensure the provision of member data and clinical information to the future MCO necessary to avoid delays in member treatment. The MCO shall have written policies and procedures to facilitate a smooth transition of a member to another MCO when a member chooses and is approved to switch to another MCO.

(4) The MCO/SE shall have policies and procedures regarding provider responsibility for discharge planning upon the member's discharge from an inpatient or residential treatment facility, and the MCO/SE shall help coordinate for a seamless transition of post-discharge care. The MCO/SE shall have a mechanism for monitoring the transition of care from an inpatient or residential treatment facility.

B. **Prior authorization and provider payment requirements:**

(1) For newly enrolled members, the MCO/SE shall honor all prior authorizations granted by HSD through its contractors or the [~~CLTS~~] CoLTS MCO for the first 30 days of enrollment or until the MCO/SE has made other arrangements for the transition of services. Providers who delivered services approved by HSD through its contractors shall be reimbursed by the MCO/SE.

(2) For members who recently became exempt from managed care or enrolled in [~~CLTS~~] CoLTS, HSD or the [~~CLTS~~] CoLTS MCO shall honor prior authorization of fee-for-service covered benefits or CoLTS covered benefits granted by the MCO/SE for the first 30 days under fee-for-service medicaid or CoLTS or until other arrangements for the transition of services have been made. Providers who deliver these services and are eligible and willing to enroll as medicaid fee-for-service providers shall be reimbursed by HSD or the CoLTS MCO.

(3) For members who had transplant services approved by HSD under fee-for-service or under [~~CLTS~~] CoLTS, the MCO shall reimburse the providers approved by HSD or [~~CLTS~~] the CoLTS MCO if a donor organ becomes available for the member during the first 30 days of enrollment.

(4) For members who had transplant services approved by the MCO, HSD or the [~~CLTS~~] CoLTS MCO shall reimburse the providers approved by the MCO if a donor organ becomes available for the member during the first 30 days under fee-for-service medicaid. Providers who deliver these services shall be eligible and willing to enroll as medicaid fee-for-service providers.

(5) For newly enrolled members, the MCO/SE shall pay for prescriptions for drug refills for the first 30 days or until the MCO/SE has made other arrangements. All drugs prescribed by a licensed behavioral health provider shall be paid for by the SE.

(6) For members who recently became exempt from managed care, HSD shall pay for prescriptions for drug refills for the first 30 days under the fee-for-service formulary. The pharmacy provider shall be eligible and willing to enroll as a medicaid fee-for-service provider.

(7) The MCO shall pay for DME costing $2,000 or more, approved by the MCO but delivered to the member after disenrollment from managed care or enrollment into [~~CLTS~~] CoLTS.

(8) HSD or the [~~CLTS~~] CoLTS MCO shall pay for DME costing $2,000 or more, approved by HSD or the [~~CLTS~~] CoLTS MCO but delivered to the member after enrollment in the MCO. The DME provider shall be eligible for and willing to enroll as a medicaid fee-for-service provider. DME is not covered by the SE unless it has been prescribed by a behavioral health provider.

C. **Special payment requirement.** The MCO shall be responsible for payment of covered physical health services, provided to the member for any month the MCO receives a capitation payment. The SE shall be responsible for payment of covered behavioral health services provided to the member for any month the SE receives a capitation payment.

D. **Claims processing and payment:** In the event that an MCO's/SE's contract with HSD [~~or the collaborative~~] has ended, is not renewed or is terminated, the MCO/SE shall remain responsible for processing and paying claims for services delivered through the contract period, but submitted after the MCO's/SE's contract has ended.

(1) The MCO/SE shall be required to inform providers in writing, at least 30 days prior to the end of the contract, of the termination of the contract and of the process for providers to submit claims for services provided through the contract end date. The letter shall include the telephone, fax numbers, and the billing address for claims submissions as well as the names of persons to contact with questions.

(2) The MCO/SE shall allow six months to process claims for services provided prior to the contract termination date.

(3) The MCO/SE shall continue to meet timeframes established for processing all claims.

[8.305.16.9 NMAC - N, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-08; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.17 NMAC, Sections 8 and 9, which will be effective July 1, 2009.

8.305.17.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost-effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.

[8.305.17.8 NMAC - N, 7-1-07; A, 7-1-09]

8.305.17.9 VALUE ADDED SERVICES: The MCO/SE shall offer members value added services. The cost of these services cannot be included when HSD determines the payment rates. Value added services are not included in the managed care medicaid benefit package. Value added services shall not be construed as medicaid funded services, benefits, or entitlements under the NM Public Assistance Act. Value added services shall be approved by and reported to HSD. The MCO/SE shall work with HSD to identify codes to be used for value added services. Value added services shall be direct services, not administrative in nature unless approved by HSD. Since value added services are not medicaid funded services, there is no appeal or fair hearing rights for the members regarding these services. A denial of a value added service will not be considered an action. The MCO/SE shall send the member a notification letter if the value added service is not approved.

A. **Potential value added services (MCO only):** The following are suggested [~~enhanced~~] value added services:

(1) anticipatory guidance provided as a part of the normal course of office visits or a health education program, including behavioral health;

(2) child birth education, parenting skills classes;

(3) child abuse and neglect prevention programs;

(4) stress control programs;

(5) car seats for infants and children;

(6) culturally-traditional indigenous healers and treatments;

(7) smoking cessation programs;

(8) weight loss and nutrition programs;

(9) violence prevention services;

(10) substance abuse prevention and treatment, beyond the benefit package; and

(11) respite care for care givers.

B. **Potential value added services (SE only):** The SE shall strategically determine a continuum of services, identify value added services needs and work with [~~the collaborative~~] HSD to develop value added services. Value added services should promote evidence based practices that support recovery and resiliency.

C. **Member specific value added services:** Other services may be made available to members based on the MCO/SE's discretion. Eligibility for value added services may be based upon a set of assessment criteria to be employed by the MCO/SE.

[8.305.17.9 NMAC - N, 7-1-07; A, 7-1-08; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.306.1 NMAC, Section 7 and 8, which will be effective July 1, 2009.

8.306.1.7 DEFINITIONS: The state of New Mexico is committed to reducing the number of uninsured working New Mexico residents and improving the number of small employers offering health benefit plans by implementation of a basic health coverage health insurance benefit provided by contracted managed care organization with cost sharing by members, employers and the state and federal governments. This section contains the glossary for the New Mexico state coverage insurance policy. The following definitions apply to terms used in this chapter.

A. Definitions beginning with letter "A":

(1) **Abuse:** Provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary cost to SCI, in reimbursement for services that are not medically necessary, or in services that fail to meet professionally recognized standards for health care. Abuse also includes member or member practices that result in unnecessary costs to SCI.

(2) **Action:** The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, modification or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure to provide services in a timely manner. An untimely service authorization constitutes a denial and is thus considered an action.

(3) **Appeal, member:** A request from a member or provider, on the member's behalf with the member's written permission, for review by the managed care organization (MCO) of an MCO action as defined above in Paragraph (2) of Subsection A of 8.306.1.7 NMAC.

(4) **Appeal, provider:** A request by a provider for review by the MCO of an MCO action related to the denial of payment or an administrative denial.

(5) **Approvals:** Approvals are either initial or concurrent review decisions, which yield utilization management authorizations based on the member meeting the clinical criteria for the requested SCI service(s) or level of care.

B. Definitions beginning with letter "B":

(1) **Behavioral health planning council (BHPC):** Refers to the council created by HB 271 to meet federal advisory council requirements and to provide consistent, coordinated input to the behavioral health service delivery in New Mexico. The SE will be expected to interact with the BHPC as an advisory council.

(2) **Behavioral health:** Refers to mental health and substance abuse[~~, including co-occurring disorders~~].

(3) **Behavioral health purchasing collaborative (the collaborative):** Refer to the interagency behavioral health purchasing collaborative pursuant to the passage of HB 271 effective May 19, 2004. The collaborative is made up of 17 publicly funded statutory member agencies including 15 direct service providers and funding agencies, including the human services department.

(4) **Benefit package:** SCI covered services that must be furnished by the MCO and for which payment is included in the capitation rate.

(5) **Benefit year:** The year beginning with the month of enrollment in an MCO and payment of designated premiums if applicable and continuing for a period up to 12 continuous months as long as enrollment requirements are met.

(6) **Broker:** A person, partnership, corporation or professional corporation appointed by a health insurer licensed to transact business in New Mexico to act as its representative in any given locality for the purpose of soliciting and writing any policy or contract insuring against loss or expense resulting from the sickness of the insured.

C. Definitions beginning with letter "C":

(1) **Capitation:** A per-member, monthly payment to an MCO that covers contracted services and is paid in advance of service delivery. It is a set amount of money received or paid out, based on membership rather than on services delivered. It is usually expressed "per member per month" (PM/PM).

(2) **Care coordination:** [~~An office-based administrative function to assist members with multiple, complex and special cognitive, behavioral or physical health care needs on an as needed basis. It is member-centered, family-focused when appropriate, culturally competent and strengths-based. Care coordination can help to ensure that the physical and behavioral health needs of the SCI population are identified and services are provided and coordinated with the individual member and family, if appropriate.~~] An office-based administrative function to assist members "at risk" for adverse outcomes to help meet their needs by filling in gaps in current health care on an as needed basis. Care coordination is member-centered, family-focused when appropriate, culturally competent and strengths-based, and ensures that the medical and behavioral health needs of the SCI population are identified and services are provided and coordinated with the member and family, as appropriate. Care coordination involves, but is not limited to, the following: planning treatment strategies; monitoring outcomes and resource use; coordinating visits with subspecialists; organizing care to avoid duplication of diagnostic tests and services; sharing information among health care professionals, other program personnel, and family; facilitating access to services; actively managing transitions of care, such as a hospital discharge; training of caregivers; and ongoing reassessment and refinement of the care plan. Care coordination operates independently within the MCO and has separately defined functions with a dedicated care coordination staff [~~, functioning independently,~~] but is structurally linked to the other MCO systems, such as quality assurance, member services, and grievances. Clinical decisions shall be based on the medically necessary covered services and not on fiscal or administrative considerations. The care coordinator coordinates services within the physical and behavioral health delivery system, as well as with other service providing systems. [~~The care coordinator may interface and collaborate with the member's case manager, if applicable, for those who receive case management services. If both physical and behavioral health conditions exist, the primary care coordination responsibility will lie with the care provider from the condition that is most acute at the time~~.] The care coordinator may interface and collaborate with the member's case manager, or refer the member to case management as necessary. If both physical and behavioral health conditions exist, the primary care coordination responsibility lies with the condition that is most acute.

(3) **Case management**: Case management consists of services which help beneficiaries gain access to needed physical health, behavioral health, social, educational, and other services. [~~Refers to a~~] A person or team of people who provide outreach to customers, provide information to them about services, work with them to develop a service plan, assist in obtaining needed services, supports and entitlements and advocate on their behalf. General case management is designed to access, coordinate and monitor services.

(4) **Category:** A designation of the automated eligibility system. SCI has one designated category (062) and three income groupings that are assigned to an individual based on their income grouping. The assigned category is applicable for a period of 12 consecutive months regardless of changes in income or family status, sub-

ject to change by request from the recipient.

(5) **Clean claim:** A manually or electronically submitted claim from a participating provider that contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside the health plan's system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. A clean claim is not materially deficient or improper, such as lacking substantiating documentation currently required by the health plan, or has no particular or unusual circumstances requiring special treatment that prevents payment from being made by the health plan within 30 days of the date of receipt if submitted electronically or 45 days if submitted manually.

(6) **Client:** An individual who has applied for and been determined eligible for SCI. A "client" may also be referred to as a "member," "customer," or "consumer", or "program participant".

(7) **CMS:** Centers for medicare and medicaid services.

(8) **Community-based care**: A system of care, which seeks to provide services to the greatest extent possible, in or near the member's home community.

(9) **Comprehensive community support services**: These services are goal-directed mental health rehabilitation services and support for children, adolescents, and adults necessary to assist individuals in achieving recovery and resiliency goals. These services assist in the development and coordination of a member's service plan and include therapeutic interventions which address barriers that impede the development of skills necessary for independent functioning in the community.

[~~(8)~~] (10) **Continuous quality improvement (CQI):** CQI is a process for improving quality that assumes opportunities for improvement are unlimited; is customer-oriented, data driven, and results in implementation of improvements; and requires continual measurement of implemented improvements and modification of improvements, as indicated.

[~~(9)~~] (11) **[~~Coordinated~~] Coordination of long-term services [~~(CLTS)~~] (CoLTS):** A coordinated program of physical health and community-based supports and services implemented under the authority of concurrent section 1915(b) and section 1915(c) waivers. The [~~CLTS~~] CoLTS program includes individuals eligible for both medicare and medicaid, and persons eligible for medicaid long-term care services based on assessed need for nursing facility level of care. The [~~CLTS~~] CoLTS program does not include individuals who meet eligibility criteria set forth in New Mexico's developmental disabilities and medically-fragile waiver programs.

[~~(10)~~] (12) **Cost-sharing:** Premiums and co-payments owed by the member based on income group category.

[~~(11)~~] (13) **Cost-sharing maximum:** The cost sharing maximum is determined during the initial eligibility determination and recertification process. The cost sharing maximum amount established at the point of eligibility determination for the benefit year represents an amount equal to [~~5%~~] five percent of the program participant's countable household income.

[~~(12)~~] (14) **Coverage:** Coverage month is a month where all eligibility and enrollment requirements including premium payment, if applicable are met.

[~~(13)~~] (15) **Cultural competence:** Cultural competence refers to a set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals, that enables them to work effectively in cross-cultural situations. Cultural competency involves the integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques and marketing programs that match an individual's culture and increase the quality and appropriateness of health care and outcomes.

D. Definitions beginning with letter "D":

(1) **Delegation:** A formal process by which the MCO gives another entity the authority to perform certain functions on its behalf. The MCO retains full accountability for the delegated functions.

(2) **Denial-administrative/technical:** A denial of authorization requests due to the requested procedure, service or item not being covered by SCI, not being on the MCO pharmacy drug list, or due to provider noncompliance with administrative policies and procedures established by either the SCI MCO or the medical assistance division[~~, except pharmaceutical services which the formulary process covers~~].

(3) **Denial-clinical:** A non-authorization decision at the time of an initial request for a SCI service or a pharmacy drug list request based on the member not meeting medical necessity for the requested service. The utilization management (UM) staff may recommend an alternative service, based on the member's need for a lower level of service. If the requesting provider accepts this alternative service, it is considered a new request for the alternative service and a clinical denial of the original service request.

(4) **Disease management plan:** A comprehensive plan following nationally recognized components for chronic disease interventions including population identification/stratification process, collaborative practice models, patient self-management education process, evidence-based practice guidelines, process and outcomes measurements, and internal quality improvement processes.

(5) **Disenrollment, MCO initiated:** When requested by an MCO for substantial reason, removal of an individual SCI member from membership in the requesting MCO, as determined by HSD, on a case-by-case basis.

(6) **Disenrollment, member initiated (switch):** When requested by a member for substantial reason, transfer of an individual SCI member as determined by HSD on a case-by-case basis, from one SCI MCO to a different SCI MCO during a member lock-in period.

(7) **Durable medical equipment (DME):** Equipment that can withstand repeated use, is primarily used to serve a medical purpose, is not useful to individuals in the absence of an illness or injury and is appropriate for use at home.

E. Definitions beginning with letter "E":

(1) **Emergency:** An emergency condition is a physical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part.

(2) **Employer:** An employer with [~~fifty~~] 50 or fewer eligible employees on a full or part time basis.

(3) **Employer group:** A group of employees employed by an eligible employer who receive SCI benefits through the employer or a self-employed person who will be considered a group of one.

(4) **Employee:** A person employed by an employer who participates in the SCI health benefit plan.

(5) **Encounter:** The record of a physical or behavioral health service rendered by a provider to an MCO member, client, customer or consumer.

(6) **Enrollee:** A SCI recipient who is currently enrolled in a managed care organization.

(7) **Enrollee rights:** Rights which each SCI enrollee is guaranteed.

(8) **Enrollment:** The process of enrolling eligible members in an MCO for purposes of management and coordination of health care delivery. The process of enrolling members either by the employer or individually in an available SCI-participating MCO for purposes of health care

coverage. Enrollment encompasses selection of an MCO, notification of the selection to the MCO, and timely payment of premiums to the MCO as determined by the MCO.

(9) **Expedited appeal:** A federally mandated provision for an expedited resolution within 72 hours of the requested appeal, which includes an expedited review by the MCO of an MCO action.

(10) **External quality review organization (EQRO):** An independent organization with clinical and health services expertise capable of reviewing the evidence of compliance of health care delivery and internal quality assurance/improvement requirements.

F. Definitions beginning with letter "F":

(1) **Family planning services:** Services provided to members of childbearing age to temporarily or permanently prevent or delay pregnancy (see 8.325.3 NMAC [MAD-762], *Reproductive Health Services*).

(2) **Fraud:** An intentional deception or misrepresentation made by an entity or person, including but not limited to, an MCO, subcontractor, provider or member with the knowledge that the deception could result in some unauthorized benefit to himself or to some other previously described entity or person. It includes any act that constitutes fraud under applicable federal or state law.

(3) **Full risk contracts:** Contracts that place the MCO at risk for furnishing or arranging for comprehensive services.

G. Definitions beginning with letter "G":

(1) **Gag order:** Subcontract provisions or MCO practices, either written, oral or implied, that effectively prevent a provider from furnishing accurate or complete information to members about options for diagnosis or treatment of physical, mental or behavioral illness, injury, or condition; or prevent a provider from talking to the member or HSD about the MCO or their business practices.

(2) **Grievance (member):** Oral or written statement by a member expressing dissatisfaction with any aspect of the MCO or its operations that is not an MCO action.

(3) **Grievance (provider):** Oral or written statement by a provider to the MCO regarding utilization management decisions or provider payment issues.

(4) **Group of one:** Individuals who enroll without an employer group but report self-employment.

H. Definitions beginning with letter "H":

(1) **Health plan:** A health maintenance organization (HMO), managed care organization (MCO), prepaid inpatient health plan (PIHP), or third party payer or their agents.

(2) **HIPAA:** Health Insurance Portability and Accountability Act of 1996.

(3) **Hospitalist:** A physician employed by a hospital to manage the care of a member admitted to the hospital for inpatient care.

(4) **Human services department (HSD):** The sole executive department in New Mexico responsible for the administration of SCI. "HSD" may also indicate the department's designee, as applicable.

I. Definitions beginning with letter "I":

(1) **Income groupings:** 0-100[~~%~~] percent, 101-150[~~%~~] percent, and 151-200[~~%~~] percent of federal poverty levels: These income groupings define the premium, copayment, and cost-sharing maximums for SCI cost-sharing purposes.

(2) **Incurred but not reported (IBNR):** Claims for services authorized or rendered for which the MCO has incurred financial liability, but the claim has not been received by the MCO. This estimating method relies on data from prior authorization and referral systems, other data analysis systems and accepted accounting practices.

(3) **Individual:** A person who enrolls in SCI who is not a member of an eligible employer group and pays the premium amount designated for both the employee share, if applicable, based on household income, and the employer share or has that amount paid on his behalf by another entity.

J. Definitions beginning with letter "J": [RESERVED]

K. Definitions beginning with letter "K": [RESERVED]

L. Definitions beginning with letter "L": [RESERVED]

M. Definitions beginning with letter "M":

(1) **Managed care organization (MCO):** An organization licensed or authorized through an agreement among state entities to manage, coordinate and receive payment for the delivery of specified services to enrolled members from a certain geographic area. Also referred to as a managed care plan and managed care program.

(2) **Marketing:** The act or process of promoting a business or commodity. Marketing includes brochures, leaflets, internet, newspaper, magazine, radio, television, billboard materials, MCO yellow page advertisements, and any other presentation materials used by an MCO, MCO representative, or MCO subcontractor to attract or retain SCI enrollment.

(3) **Medicaid:** The medical assistance program authorized under Title XIX of the Social Security Act or its successors, furnished to New Mexico residents who meet specific eligibility requirements.

(4) **Medicaid/clinical home:** A conceptual model that facilitates the provision of quality care that is accessible, family-centered, continuous, coordinated, compassionate and culturally competent.

[~~(4)~~] (5) **Medically necessary services:**

(a) Medically necessary services are clinical and rehabilitative physical or behavioral health services that:

(i) are essential to prevent, diagnose or treat medical or behavioral health conditions or are essential to enable the individual to attain, maintain or regain functional capacity;

(ii) are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical and behavioral health care needs of the individual;

(iii) are provided within professionally accepted standards of practice and national guidelines; and

(iv) are required to meet the physical and behavioral health needs of the individual and are not primarily for the convenience of the individual, the provider or the payer.

(b) Application of the definition:

(i) a determination that a health care service is medically necessary does not mean that the health care service is a covered benefit or an amendment, modification or expansion of a covered benefit;

(ii) the MCO/SE making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the SCI benefit package applicable to an eligible individual shall do so by: 1) evaluating individual physical and behavioral health information provided by qualified professionals who have personally evaluated the individual within their scope of practice, who have taken into consideration the individual's clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training, as appropriate; 2) considering the views and choices of the individual or the individual's legal guardian, agent or surrogate decision maker regarding the proposed covered service as provided by the clinician or through independent verification of those views; and 3) considering the services being provided concurrently by other service delivery systems;

(iii) physical and behavioral health services shall not be denied solely because the individual has a

poor prognosis; required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible individual solely because of the diagnosis, type of illness or condition.

[~~(5)~~] (6) **Member:** A eligible member enrolled in an MCO.

[~~(6)~~] (7) **Member month:** A calendar month during which a member is enrolled in an MCO.

(8) **Mi via home and community-based waiver**: The New Mexico self-directed medicaid waiver program that supports New Mexicans with disabilities and the elderly by allowing recipients to be active participants in choosing where and how they live and what services and supports they purchase.

N. Definitions beginning with letter "N":

(1) **National committee for quality assurance (NCQA):** A private national organization that develops quality standards for managed health care.

(2) **Network provider:** An individual provider, clinic, group, association or facility employed by or contracted with an MCO to furnish physical or behavioral health services to the MCO's members under the provisions of the SCI managed care contract.

(3) **Notice:** A written statement that includes what action is being taken, the reasons for the intended action, the specific regulation that requires the action, and an explanation of the circumstances under which the service may be continued if a hearing is requested.

O. Definitions beginning with letter "O": **Outreach:** The act or process of promoting an insurance product through established business channels of communications including brochures, leaflets, internet, print media, electronic media, signage or other materials used by MCOs to attract or retain SCI enrollment primarily through employer groups.

P. Definitions beginning with letter "P":

(1) **Parental or custodial relative status:** The state of having a dependent child under the age of 18 who is the son, daughter, or relative within the fifth degree of relationship living in the household and under the care and control of the individual.

(2) **Pend decision:** A prior authorization decision is considered pended when the decision is delayed due to lack of documentation, inability to contact parties involved or other reason which delays finalizing an approval. A decision by an MCO to pend approval does not extend or modify required utilization management decision timelines.

(3) **Performance improvement project (PIP):** An MCO program activity must include projects that are designed to achieve significant improvement in clinical or non-clinical care areas. PIPs must involve measurements using objective quality indicators, system intervention to achieve improvement, evaluation of the effectiveness of interventions and activities for increasing or sustaining improvement. Outcomes must be measurable over a period of time.

[~~(3)~~] (4) **Performance measurement (PM):** Data specified by the state that enables the MCO's performance to be determined.

[~~(4)~~] (5) **Plan of care:** A written document including all medically necessary services to be provided by the MCO for a specific member.

[~~(5)~~] (6) **Policy:** The statement or description of requirements.

[~~(6)~~] (7) **Potential enrollee:** A medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO.

[~~(7)~~] (8) **Pregnancy-related services:** Medically necessary medical or surgical services related to pregnancy, including procedures to terminate pregnancy.

[~~(8)~~] (9) **Preventative health services:** Services that follow current national standards for prevention including both physical and behavioral health.

[~~(9)~~] (10) **Primary care:** All health services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, physician assistant or certified nurse practitioner.

[~~(10)~~] (11) **Primary care provider (PCP):** A provider who agrees to manage and coordinate the care provided to members in the managed care program.

[~~(11)~~] (12) **Procedure:** Process required to implement a policy.

Q. Definitions beginning with letter "Q": [RESERVED]

R. Definitions beginning with letter "R":

(1) **Rate cell:** A combination of category of eligibility and demographics used to isolate utilization patterns for the determination of capitation.

(2) **Received but unpaid claims (RBUC):** Claims received by the MCO but not paid affecting appropriate expense and aging accounting categories. Such claims are counted as of the date of receipt by the MCO.

(3) **Reduction of care:** A utilization management staff authorization of the type of service requested by the provider but in lesser amounts or units of service, based on the member's physical health, medical or behavioral health clinical need, than was originally requested, except pharmaceutical services which are covered by the formulary process.

(4) **Referral:** Any specialty, inpatient, outpatient, or diagnostic services that a physician or physician group orders or arranges, but does not provide directly.

(5) **Reinsurance:** Reinsurance is a proactive financial tool that may be used by an MCO to minimize exposure to losses incurred when members utilize health care services beyond anticipated levels or overall member utilization is greater than expected.

(6) **Risk:** The possibility that revenues of the MCO will not be sufficient to cover expenditures incurred in the delivery of contractual services.

(7) **Routine care:** All care, which is not emergent or urgent.

S. Definitions beginning with letter "S":

(1) **Salud!:** the New Mexico managed care program implemented in 1997, covering children, pregnant women and disabled New Mexicans. Parents of medicaid-eligible children are also covered by medicaid if they meet eligibility requirements.

[~~(1)~~] (2) **SCI (state coverage insurance):** The New Mexico health care program implemented under the authority of the health insurance flexibility and accountability (HIFA) waiver granted to the state by the centers for medicare and medicaid services (CMS).

[~~(2)~~] (3) **SCI members with special health care needs (SCI-SHCN):** Individuals who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition, or low to severe functional limitation and who also require health and related services of a type or amount beyond that required by individuals generally.

[~~(3)~~] (4) **Single statewide entity (SE):** Refers to the entity selected by the state of New Mexico through the collaborative to perform all contract functions defined in the behavioral health request for proposal (RFP). The SE is a single contractor selected to provide all defined service responsibilities statewide, including medicaid behavioral health benefits. The SE will receive delegation by the MCO for SCI managed care. The SE shall contract with the MCO and may be responsible for contracting with providers, paying provider claims, assuring care coordination, conducting utilization review and utilization management activities, assuring quality review and service delivery improvement, credentialing practitioners and provider agencies, privileging practitioners to deliver critical services or service approaches, evaluating and monitoring of service delivery and conducting any other administrative functions necessary to achieve the goals of the collab-

orative. The SE is the agent of the collaborative and shall "coordinate," "braid" or "blend" the funding, human resources and service capacity available from the various state agencies so as to increase flexibility, maximize available resources and create a seamless single behavioral health service delivery system for New Mexico."

[~~(4)~~] (5) **Subcontract:** A written agreement between the MCO and a third party, or between a subcontractor and another subcontractor, to provide services.

[~~(5)~~] (6) **Subcontractor:** A third party who contracts with the MCO or an MCO subcontractor for the provision of services.

T. Definitions beginning with letter "T":

(1) **Terminations of care:** The utilization management review decision made during a concurrent review, which yields a denial, based on the current service being no longer medically necessary.

(2) **Third party:** An individual entity or program, which is or may be, liable to pay all or part of the expenditures for SCI members for services furnished.

(3) **Transition of care:** Refers to the movement of patients from one health care practitioner or setting to another as their condition and care requires change.

U. Definitions beginning with letter "U": **Urgent condition:** Acute signs and symptoms, which, by reasonable medical judgment, represent a condition of sufficient severity such that the absence of medical attention within 24 hours could reasonably be expected to result in an emergency condition.

V. Definitions beginning with the letter "V": **Value added benefit:** Any benefit offered to members by the MCO that is not included in the SCI benefit package.

[8.306.1.7 NMAC - N, 7-1-05; A, 3-1-06; A, 4-16-07; A, 6-1-08; A, 7-1-09]

8.306.1.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their community.

[8.306.1.8 NMAC - N, 7-1-05; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.306.2 NMAC, Sections 8 and 9, which will be effective July 1, 2009.

8.306.2.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their community.

[8.306.2.8 NMAC - N, 7-1-05; A, 7-1-09]

8.306.2.9 MEMBER EDUCATION: SCI members shall be advised of their rights, responsibilities, service availability and administrative roles under SCI. Member education is initiated when a member becomes eligible for SCI with information provided by HSD and the managed care organization (MCO).

A. **Initial information:** Various outreach and media strategies are designed to reach employers, employees, as well as non-employed individuals; to ensure that all eligible New Mexicans are aware of the availability of SCI. Marketing is especially targeted to employers not currently offering insurance as well as to employers who offer insurance but whose employees cannot afford the required premium sharing. Initial member education is provided by the MCO and brokers and through outreach materials available from HSD.

B. **MCO enrollment information:** Once an individual enrollee or employee is determined to be eligible for the SCI program, his employer, broker, or MCO will provide the member information about services included in the MCO benefit package.

C. **Informational materials:** The MCO is responsible for providing members and potential members, upon request, a member handbook and a provider directory. The member handbook and the provider directory shall be available in languages other than English, if there is a greater than [~~5%~~] five percent incidence of another language spoken within the MCO membership as determined by the MCO or HSD.

(1) The member handbook shall include the following:

(a) MCO demographic information, including the organization's hotline telephone number;

(b) information on how to obtain services such as after-hours and emergency services, including the 911 telephone system or its local equivalent;

(c) patient bill of rights and member responsibilities, including any restrictions on the member's freedom of choice among network providers;

(d) information pertaining to coordination of care by and with PCPs;

(e) how to obtain care in emergency and urgent conditions and that prior authorization is not required for emergency services;

(f) [~~description~~] the amount, duration and scope of benefits;

(g) information on accessing behavioral health or other specialty services,

(h) limitations to the receipt of care from out-of-network providers for non-emergency care;

(i) a list of services for which prior authorization or a referral is required and the method of obtaining both;

(j) a policy on referrals for specialty care and other benefits not furnished by the member's PCP;

(k) notice to members about the grievance process and about HSD's fair hearing process;

(l) information on the member's right to terminate enrollment and the process for voluntarily disenrolling from the plan;

(m) information regarding advance directives;

(n) information regarding obtaining a second medical opinion;

(o) information on cost sharing, cost sharing maximums and maximum benefit amounts per benefit year[~~.~~];

(p) how to obtain information, determined by HSD as essential during the member's initial contact with the MCO, which may include a request for information regarding the MCO's structure, operation, and physician's or senior staff's incentive plans[~~,~~];

(q) information regarding the birthing option program; and

(r) language that clearly explains that a Native American SCI member may self-refer to an Indian health service or tribal health care facility for services.

(2) The provider directory shall include the following:

(a) MCO addresses and telephone numbers;

(b) a listing of primary care and self-refer specialty providers with the name, location, phone number, and qualifications including areas of special expertise and non-English languages spoken that would be helpful to members; MCO-contracted specialty providers for self-referral shall include, but not be limited to, [~~family planning providers,~~] point-of-entry behavioral health providers, urgent and emergency care providers, Indian health service[~~,other Native American providers and pharmacies~~] and tribal health care providers including hospitals, outpatient clinics, and pharmacies; and

(c) the material shall be available in a manner and format that can be easily understood by all populations who exceed a greater than [~~5%~~] five percent incidence in the total MCO membership as identified by the MCO and HSD.

D. **Other requirements:**

(1) The MCO shall provide the member handbook and provider directory to enrolled members within 30 calendar days of enrollment.

(2) The handbook and directory shall be provided in a comprehensive, understandable format that takes into consideration the special needs population, is in accordance with federal mandates and meets communication requirements delineated in 8.305.8.15 NMAC, *member bill of rights*. This information may also be accessible via the internet and be provided as requested by HSD. The MCO shall have a process in place for notifying members of the availability of this information in alternative formats.

(3) Oral and sign language interpretation shall be made available free of charge to members and to potential members, upon request, and be available in non-English languages for populations that exceed a greater than [~~5%~~] five percent incidence within the MCO's membership as defined by the MCO and HSD.

(4) The member handbook shall be approved by HSD prior to distribution to SCI members.

(5) Notification of material changes in the administration of the MCO changes in the MCO's provider network, significant changes in applicable state law, and any other information deemed relevant by HSD shall be distributed to the members [~~thirty days (30)~~] 30 days prior to the intended effective date of the change. In addition, the MCO shall make a good faith effort to give written notice of termination of a contracted provider within 15 days after receipt or issuance of a termination notice.

(6) Notification to members about any of these changes may be made without reprinting the entire handbook.

(7) The MCO shall notify all members at least once per year of their right to request and obtain member handbooks and provider directories.

E. **MCO policies and procedures on member education:** The MCO shall maintain policies and procedures governing the development and distribution of educational material for members. Policies shall address how members and potential members receive information, the means of dissemination and the content, comprehension level and languages used. The MCO shall have written policies and procedures regarding the utilization of information on race, ethnicity and primary language spoken by its membership.

F. **Health education:** The MCO shall provide a continuous program of health education without cost to members. Such a program may include publications (brochures, newsletters), electronic media (films, videotapes), presentations (seminars, lunch-and-learn sessions) and classroom instruction. The MCO shall provide programs of wellness education, including programs provided to address the social, physical, behavioral and emotional consequences of high-risk behaviors. HSD approval of health education materials is not required.

G. **Maintenance of toll-free line:** The MCO shall maintain one or more toll-free telephone lines that are accessible 24 hours a day, seven days a week, to facilitate member access to a qualified clinical staff to answer health-related questions. MCO members may also leave voice mail messages to obtain other MCO policy information and to register grievances with the MCO. The MCO shall return the telephone call by the next business day.

[8.306.2.9 NMAC - N, 7-1-05; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.306.3 NMAC, Sections 8, 10 and 11, which will be effective July 1, 2009.

8.306.3.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost-effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their community.

[8.306.3.8 NMAC - N, 7-1-05; A, 7-1-09]

8.306.3.10 CONTRACT MANAGEMENT:

A. **General contract requirements:** The MCOs shall meet all specified terms of the SCI contract and the Health Insurance Portability and Accountability Act (HIPAA). This includes, but is not limited to, insuring confidentiality as it relates to medical records and any other health and enrollment information that identifies a particular member. The MCO will be held harmless in conversion to HIPAA electronic transmission formats when delays are the result of implementation issues at HSD. HSD is responsible for management of the SCI managed care contracts issued to MCOs. HSD shall provide the oversight and administrative functions to ensure MCO compliance with the terms of the SCI managed care contract.

B. **Subcontracting requirements:** The MCO may subcontract to a qualified individual or organization the provision of any service defined in the benefit package or other required MCO [~~function~~] functions with HSD's approval. The MCO shall be legally responsible to HSD for all work performed by any MCO subcontractor. The MCO shall submit boilerplate contract language and sample contracts for various types of subcontracts.

(1) **Credentialing requirements:** The MCO shall maintain policies and procedures for verifying for HSD's approval. Any substantive changes to contract templates shall be approved by HSD prior to issuance that the credentials of its providers and subcontractors meet applicable standards.

(2) **Review requirements:** The MCO shall maintain a fully executed original of all subcontracts and make them available to HSD on request.

(3) **Minimum requirements:** Subcontracts shall contain the following provisions:

(a) subcontracts shall be executed in accordance with applicable federal and state laws, regulations, policies and rules;

(b) subcontracts shall identify the parties of the subcontract and the parties' legal basis [~~of operation~~] to operate in the state of New Mexico;

(c) subcontracts shall include [~~procedures and criteria for terminating the subcontract~~] the frequency of reporting (if applicable) to the MCO and the process by which the MCO evaluates the delegate;

(d) subcontracts shall identify the services to be performed by the subcontractor including a description of how members access services provided under the subcontract;

(e) subcontracts shall include reimbursement rates and risk assumption, where applicable;

(f) subcontractors shall maintain records relating to services provided to members for ten years;

(g) subcontracts shall require that member information be kept confidential, as defined by federal or state law and be HIPAA compliant;

(h) subcontracts shall provide that authorized representatives of HSD have reasonable access to facilities, personnel and records for financial and medical audit purposes;

(i) subcontracts shall [~~provide~~] include a provision for the subcontractor to release to the MCO any information necessary to perform any of its obligations;

(j) the subcontractor shall accept payment from the MCO for any services provided under the benefit package and may not request payment from HSD for services performed under the subcontract;

(k) if the subcontract includes primary care, the subcontractor shall comply with PCP requirements delineated in the MCO contract with HSD;

(l) the subcontractor shall comply with all applicable state and federal statutes, rules and regulations, including prohibitions

against discrimination;

(m) subcontracts shall have procedures and criteria for terminating the subcontract and provisions for the imposition of sanctions for inadequate subcontractor performance and for terminating, rescinding, or canceling the contracts for violation of applicable HSD requirements;

[~~(m)~~] (n) the subcontract shall not prohibit a provider or other subcontractor from entering into a contractual relationship with another MCO;

(o) subcontracts may not include incentives or disincentives that encourage a provider or other subcontractor not to enter into a contractual relationship with another MCO;

[~~(n)~~] (p) [~~the subcontract shall allow providers to assist members to access the grievance process or to act to protect member interests;~~] subcontracts shall not contain any gag order provisions nor sanctions against providers who assist members in accessing the grievance process or otherwise act to protect members' interests;

[~~(o)~~] (q) [~~the subcontract~~] subcontracts shall specify the time frame for submission of encounter data to the MCO;

[~~(p)~~] (r) subcontracts to entities that receive annual medicaid payments of at least $5 million shall include detailed information regarding employee education of the New Mexico and federal False Claims Act; [~~and~~]

[~~(q)~~] (s) subcontracts shall include a provision requiring [~~subcontractors~~] the subcontractor to perform criminal background checks for all required individuals providing services;

(t) subcontracts shall include a provision requiring providers to submit claims electronically; low volume or low dollar providers may have this requirement waived; and

(u) subcontracts shall include the HSD contractual provisions of the state of New Mexico Executive Order 2007-049 concerning subcontractor health coverage requirements.

(4) **Excluded providers:** The MCO shall not contract with any individual provider, or entity, or entity with an officer, director, agent, or manager who owns or has a controlling interest in the entity, who has been convicted of crimes specified in Section 1128 of the Social Security Act; has been excluded from participation in any other state's medicaid, medicare, or any other public or private health or health insurance program; has been assessed a civil penalty under the provision of Section 1128; or who has had a contractual relationship with an entity or individual convicted of a crime specified in Section 1128.

C. **Provider incentive plans:** The MCO shall ensure that direct or indirect incentives offered in the subcontract shall not serve as an inducement to reduce or limit medically necessary services to members.

[8.306.3.10 NMAC - N, 7-1-05; A, 4-16-07; A, 6-1-08; A, 7-1-09]

8.306.3.11 ORGANIZATIONAL REQUIREMENTS:

A. **Organizational structure:** The MCO shall provide the following information to HSD and updates, modifications, or amendments to HSD within 30 days:

(1) current organization charts or other written plans identifying organizational lines of accountability;

(2) articles of incorporation, bylaws, partnership agreements, or similar documents that describe the
MCO's mission, organizational structure, board and committee composition, mechanisms to select officers and directors and board and public meeting schedules; and

(3) documents describing the MCO's relationship to parent-affiliated and related business entities including, but not limited to, subsidiaries, joint ventures or sister corporations.

B. **Policies, procedures and job descriptions:** The MCO shall establish and maintain written policies, procedures and job descriptions as required by HSD. The MCO shall establish, maintain and implement guidelines for developing, reviewing and approving policies, procedures and job descriptions. The MCO shall provide MCO policies, procedures, and job descriptions for key personnel and guidelines for review to HSD on request. The MCO shall notify HSD within 30 days when changes occur in key personnel.

(1) **Review of policies and procedures:** The MCO shall review the MCO's policies and procedures at least every two years, unless otherwise specified herein, to ensure that they reflect the MCO's current best industry practices. Job descriptions shall be reviewed to ensure that current employee duties reflect written requirements. Substantive modification or amendment to key positions shall be reviewed by HSD.

(2) **Distribution of information:** The MCO shall distribute to providers information necessary to ensure that providers meet all contract requirements.

(3) **Business requirements:** The MCO shall have the administrative, information and other systems in place necessary to fulfill the terms of the SCI managed care contract. Any change in identified key MCO personnel shall conform to the requirements of the SCI managed care contract. The MCO shall retain financial records, supporting documents, statistical records, and all other records for a period of 10 years from the date of submission of the final expenditure report, except as specified by HSD.

(4) **Financial requirements:** The MCO shall meet the requirements of federal and state law with respect to solvency and performance guarantees for the duration of the SCI managed care contract. The MCO shall meet additional financial requirements specified in the SCI managed care contract.

(5) **Member services:** The MCO shall have a member services function that coordinates communication with members and acts as a member advocate. Member services shall include sufficient staff to assist members in resolving problems or making inquiries. The MCO's policies and procedures shall be made available on request to members or member representatives for review during normal business hours.

(6) **Consumer advisory board:** [~~The MCO shall establish representation on its current medicaid managed care consumer advisory board that includes SCI. This representation may have regional representation of consumers, family members, advocates and providers who participate in SCI. The MCO can also devise a method, approved by HSD/MAD, to elicit feedback from SCI consumers and address their needs, if~~] The MCOs shall establish their respective consumer advisory board that includes regional representation of consumers, family members, advocates and providers. The consumer advisory boards shall interface and collaborate with one another as appropriate. If formation of a separate SCI consumer advisory board is deemed impractical because of enrollment of less than 2,500 members, the MCO shall include at least three SCI members in the Salud! consumer advisory board meetings.

(a) Consumer advisory board members shall serve to advise the MCO on issues concerning service delivery and quality of service, the member bill of rights and member responsibilities, resolution of member grievances and the needs of groups represented by board [~~members~~] membership as they pertain to SCI. The MCO will hold quarterly centrally-located meetings during the year. The attendance roster and minutes shall be made available to HSD on request. The MCO shall advise HSD at least 10 days in advance of meetings to be held. HSD shall attend and observe the MCO's consumer board meetings at its discretion.

(b) [~~The MCO shall attend at least two statewide consumer-driven or hosted meetings, relevant to the SCI population, per year, of the MCO's choosing, that focus on consumer issues and needs to ensure that~~

~~member's concerns are heard and addressed.~~] The MCO will hold two regional consumer advisory board meetings per contract year that focus on consumer issues and needs to ensure that member's concerns are heard and addressed. Attendance rosters and minutes for these two regional meetings shall be made available to HSD.

(7) **Requirements for Native American membership:** Per HSD direction, the MCO shall hold at least one annual meeting with Native American representatives from around the state of New Mexico who represent membership demographics. The minutes of such meetings shall be submitted to HSD within 30 days of such meetings.

[~~(7)~~] C. **Contract enforcement:** HSD shall enforce contractual and state and federal regulatory requirements specified in the scope of work of the contract. HSD may use the following types of sanctions for less than satisfactory or nonperformance of contract provisions:

[~~(a)~~] (1) require plans of correction;

[~~(b)~~] (2) impose directed plans of correction;

[~~(c) impose civil or administrative monetary penalties and fines under the following guidelines:~~]

(3) impose monetary penalties to the extent authorized by federal or state law:

(a) HSD retains the right to apply progressively stricter sanctions against the MCO, including an assessment of a monetary penalty against the MCO, for failure to perform in any contract area;

(b) unless otherwise required by law, the level of sanctions shall be based on the frequency or pattern of conduct, or the severity or degree of harm posed to or incurred by members or the integrity of the SCI program;

(c) a monetary penalty, depending on the severity of the infraction; penalty assessments shall range up to five percent of the MCO's SCI capitation payment in the month in which the penalty is assessed;

(d) any withholding of capitation payments in the form of a penalty assessment does not constitute just cause for the MCO to interrupt services provided to members; and

(e) all administrative, contractual or legal remedies available to HSD shall be employed in the event that the MCO violates or breaches the terms of the contract;

(4) impose other civil or administrative monetary penalties and fines under the following guidelines:

[~~(i)~~] (a) a maximum of $25,000.00 for each of the following determinations: failure to provide service; misrepresentation or false statements to members, potential members, or health care providers; failure to comply with physician incentive plan requirements; and marketing violations;

[~~(ii)~~] (b) a maximum of $100,000.00 for each of the following determinations: discrimination or misrepresentation or false statements to HSD[~~,~~] or CMS;

[~~(iii)~~] (c) a maximum of $15,000.00 for each SCI member that HSD determines was not enrolled, or reenrolled, or enrollment was terminated because of a discriminatory practice; this is subject to an overall limit of $100,000.00; and

[~~(iv)~~] (d) a maximum of $25,000.00 or double the amount of the excess charges, whichever is greater, for premiums or charges in excess of the amount permitted under the SCI program; the state shall deduct from the penalty the amount of overcharge and return it to the affected [~~enrollee; and~~] enrollees.

[~~(d)~~] (5) rescind marketing consent;

[~~(e)~~] (6) suspend new enrollment, including default enrollment after the effective date of the sanction;

[~~(f)~~] (7) appoint a state monitor, the cost of which shall be borne by the MCO;

[~~(g)~~] (8) deny payment [~~of capitation rates~~];

[~~(h)~~] (9) assess actual damages;

[~~(i)~~] (10) assess liquidated damages;

[~~(j)~~] (11) remove members with third party coverage from enrollment with the MCO;

[~~(k)~~] (12) allow members to terminate enrollment;

[~~(l)~~] (13) suspend or terminate MCO contract;

[~~(m)~~] (14) apply other sanctions and remedies specified by HSD; and

[~~(n)~~] (15) impose temporary management only if it finds, through on-site survey, enrollee complaints, or any other means that:

[~~(i) there is continued behavior by the MCO as described under sub paragraph (c) above including but not limited to behavior that is prohibited under specific federal law granting states appropriations for Medicaid services, 42 USC Sections 139b(m) or 1396u-2; or~~]

(a) there is continued egregious behavior by the MCO, including but not limited to behavior that is described under paragraph (4) above or that is contrary to any requirements of 42 USC Sections 1396b(m) or 1396u-2; or

[~~(ii)~~] (b) there is substantial risk to member's health; or

[~~(iii)~~] (c) the sanction is necessary to ensure the health and safety of the MCO's members while improvement is made to remedy violations made under [~~Subparagraph (c)~~] paragraph (4) above; or until there is orderly termination or reorganization of the MCO; and

[~~(iv) there shall be no provision for hearing prior to the imposition of temporary management and HSD shall not terminate temporary management until it determines that the MCO can ensure that the sanctioned behavior will not re-occur.~~]

(d) HSD shall not delay the imposition of temporary management to provide a hearing before imposing this sanction; HSD shall not terminate temporary management until it determines that the MCO can ensure that the sanctioned behavior will not re-occur; refer to state and federal regulations for due process procedures.

[8.306.3.11 NMAC - N, 7-1-05; A, 4-16-07; A, 6-1-08; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.306.4 NMAC, Sections 8 and 11, which will be effective July 1, 2009.

8.306.4.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their community.

[8.306.4.8 NMAC - N, 7-1-05; A, 7-1-09]

8.306.4.11 MANAGED CARE STATUS CHANGE: A change of SCI eligibility for a member enrolled in an MCO may result in managed care disenrollment or change of enrollment status within the MCO, including but not limited to receipt of medicaid or medicare, which may be provided retroactively; failure to complete annual recertification for the program; or failure to make required premium payments.

[8.306.4.11 NMAC - N, 7-1-05; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.306.5 NMAC, Sections 8 and 9, 13 and 14, which will be effective July 1, 2009.

8.306.5.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and dis-

abled individuals in New Mexico equal participation in the life of their community.
[8.306.5.8 NMAC - N, 7-1-05; A, 7-1-09]

8.306.5.9 ENROLLMENT PROCESS:

A. **Enrollment requirements:** The managed care organization (MCO) shall provide an open enrollment period during which the MCO will enroll individuals in accordance with accepted MCO practice in the order in which they apply, up to the limits contained in the contract. The MCO shall not discriminate on the basis of health status or a need for health care services. The MCO shall not discriminate against individuals eligible to enroll on the basis of disability, race, color, national origin, or sexual orientation. The MCO shall not use any policy or practice that has the effect of discriminating on the basis of disability, race, color, national origin, or sexual orientation. All enrollments shall be voluntary and based on member or employer choice.

B. **Member lock-in:** Except as otherwise provided below, once a member in an employer group has enrolled in an MCO through his employer group, he may only transfer to another MCO, 1) during the employer enrollment period, that occurs when the employer contracts with another MCO; or 2) if he changes employers. A member enrolled individually may only transfer to another MCO when his eligibility is recertified or "for cause" as defined as follows: the following criteria shall be cause for transfer:

(1) continuity of care issues;

(2) family continuity;

(3) administrative or data entry error in assigning a client to an MCO;

(4) assignment of a member where travel for primary care exceeds community standards (90[~~%~~] percent of urban residents shall travel no further than 30 miles to see a PCP; 90[~~%~~] percent of rural residents shall travel no further than 45 miles to see a PCP; and 90[~~%~~] percent of frontier residents shall travel no further than 60 miles to see a PCP); urban counties are: Bernalillo, Los Alamos, Santa Fe and Dona Ana; frontier counties are: Catron, Harding, DeBaca, Union, Guadalupe, Hidalgo, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, San Miguel and Cibola; rural counties are those which are not listed as urban or frontier;

(5) the member moves out of the MCO service area;

(6) the MCO does not, because of moral or religious objections, cover the service the member seeks;

(7) the member needs related services to be performed at the same time, not all related services can be provided by the PCP, and another provider determines that receiving the services separately would subject the member to unnecessary risk; and

(8) other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs; if applicable, the member shall be notified by the MCO, 60 days prior to the expiration of the member's lock-in period of the deadline for selecting a new MCO; members in an employer group will be notified of the employer enrollment period by the employer or the broker, if applicable; members who are not in an employer group will be notified of the expiration of their lock-in period by the MCO.

C. **Selection period:** After receiving a letter of eligibility from the ISD office or an enrollment packet from the MCO, a new individual member shall complete enrollment with an MCO within a [~~30~~] 90 day period. If enrollment, including payment of any required premium, is not made within that timeframe, the member shall be considered to have voluntarily dropped the SCI insurance coverage, which means that the individual[~~,~~] may not enroll with an SCI MCO for six months, beginning with the individual's eligibility start date. An employer group has a specified time period, determined by the MCO and HSD, in which to complete enrollment and premium payment with an SCI MCO after all employees have received their letters of eligibility. Failure of the employer to complete the enrollment process within this time period will deem the employer to have voluntarily dropped insurance coverage and the employer will be ineligible to enroll with an SCI MCO for a [~~twelve~~] 12-month period; however, the individual employees are eligible to enroll immediately as individuals and will not be considered to have voluntarily dropped health insurance coverage.

D. **Beginning date of enrollment:** Enrollment begins the first day of the first full month following receipt of eligibility letter and MCO completion of enrollment including receipt of required premiums. However, if MCO receipt of required premium payment occurs after the HSD-approved designated day of the month and before the first full day of the following month, the enrollment begins on the first day of the second full month after MCO receipt of premium payments.

E. **Member switch enrollment:** A member enrolled as an individual and not as an employee enrolled through an employer group may request to be disenrolled from an MCO and switch to another MCO (if available) "for cause" at any time. The request shall be made in writing to HSD. HSD shall review the request and furnish a written response to the member and the MCO in a 30 day period. The following criteria shall be used to make a decision regarding a switch enrollment request:

(1) continuity of care issues;

(2) family continuity;

(3) administrative or data entry error in enrolling a member with an MCO;

(4) travel for primary care exceeds community standards, (90[~~%~~] percent of urban residents shall travel no further than 30 miles to see a PCP; 90[~~%~~] percent of rural residents shall travel no further than 45 miles to see a PCP; and 90[~~%~~] percent of frontier residents shall travel no further than 60 miles to see a PCP); urban counties are: Bernalillo, Los Alamos, Santa Fe and Dona Ana; frontier counties are: Catron, Harding, DeBaca, Union, Guadalupe, Hidalgo, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, San Miguel and Cibola; rural counties are those which are not listed as urban or frontier;

(5) the member moves out of the MCO service area;

(6) the MCO does not, because of moral or religious objections, cover the service the member seeks;

(7) the member needs related services to be performed at the same time, not all related services can be provided by the PCP, and another provider determines that receiving the services separately would subject the member to unnecessary risk; and

(8) other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs; if applicable, the member shall be notified by the MCO, 60 days prior to the expiration of the member's lock-in period of the deadline for selecting a new MCO; members in an employer group will be notified of the employer enrollment period by the employer or the broker, if applicable; members who are not in an employer group will be notified of the expiration of their lock-in period by the MCO.

F. **Disenrollment, MCO initiated:** The MCO may request that a particular member be disenrolled. Other than for non-payment of premiums, member disenrollment from an MCO will be considered only in rare circumstances. Disenrollment requests shall be made in writing to HSD. The MCO shall notify the member in writing of the disenrollment request at the same time the request is submitted to HSD. The MCO shall submit a copy of the member's notification letter to HSD. If the disenrollment is granted, the MCO retains responsibility for the member's care until the member is enrolled with another SCI- contracted MCO. If the member is part of an employer group and the

employer does not contract with another MCO, HSD may allow the member to enroll with another MCO, but the member shall be responsible for the employer's premium share, if required. The MCO shall assist with transition of care to the other MCO.

G. **Conditions under which an MCO requests member disenrollment:** The MCO may not seek to terminate enrollment because of an adverse change in the member's health. The MCO shall not request disenrollment because of an adverse change in the member's health status or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his special needs, except when his continued enrollment with the MCO seriously impairs the MCO's ability to furnish services to either this particular member or other members. The MCO shall notify the member in writing of the disenrollment request at the same time the request is submitted to HSD. The MCO shall submit a copy of the member's notification letter. If the disenrollment is granted, the MCO retains responsibility for the member's care until the member is enrolled with another MCO. The MCO shall assist with transition of care.

H. **Re-enrollment limitations:** If a request for disenrollment is approved, the member shall not be re-enrolled with the requesting MCO for a period of time to be determined by HSD. The member and the requesting MCO shall be notified by HSD of the period of disenrollment. If a member has been disenrolled by all available contracted MCOs, HSD shall evaluate the member for termination from SCI.

I. **Date of disenrollment:** MCO enrollment shall terminate at the end of the month following the month in which HSD approval for disenrollment is granted.

[8.306.5.9 NMAC - N, 7-1-05; A, 3-1-06; A, 4-16-07; A/E, 8-1-07; A, 7-1-09]

8.306.5.13 MASS TRANSFER PROCESS: The mass transfer process is initiated when HSD determines that the transfer of MCO members from one MCO to another is appropriate.

A. **Triggering mass transfer process:** The mass transfer process may be triggered by two situations:

(1) a maintenance change, such as changes in MCO identification number or MCO name; and

(2) a significant change in MCO contracting status, including but not limited to, loss of licensure, substandard care, fiscal insolvency or significant loss in network providers.

B. **Effective date of mass transfer:** The change in enrollment initiated by the mass transfer begins with the first day of the month following the identification of the need to transfer MCO members.

[~~C. **Member selection period:** Following a mass transfer, MCO members or employers as applicable are given an opportunity to select a different MCO, if available.~~

~~D.~~] C. **Mass transfer based on significant change in contracting status:** The mass transfer function is triggered when the MCO's contract status changes and the change may be significant to the MCO member. Upon initiation of the mass transfer function by HSD, [~~MCO members are transferred to a different MCO and~~] a notice is sent to members informing them of the transfer and their opportunity to select a different MCO, if available. HSD will work with employers to contract with the new MCO(s).

[8.306.5.13 NMAC - N, 7-1-05; A, 7-1-09]

8.306.5.14 SCI MARKETING-OUTREACH GUIDELINES: When marketing to SCI members, the MCOs shall follow the SCI marketing guidelines.

A. **Minimum marketing and outreach requirements:** Marketing is defined as the act or process of promoting a business or commodity. The marketing and outreach material shall meet the following minimum requirements:

(1) marketing and outreach materials shall meet requirements for all communication with SCI members, as required in the quality standards (8.305.8.15 NMAC, *member bill of rights*) and incorporated into the managed care contract;

(2) all marketing or outreach materials produced by the MCO under the SCI contract shall state that such services are funded in part under contract with the state of New Mexico;

(3) marketing and outreach information provided to members shall be accurate, not misleading, and non-threatening;

(4) if there is a population of greater than [~~5%~~] five percent in the MCO membership, as identified by the MCO and HSD, that has limited English proficiency, as identified by the MCO or HSD, marketing materials shall be available in the language of that population; and

(5) other requirements specified by the state.

B. **Scope of marketing guidelines:** Marketing materials are defined as brochures and leaflets; newspaper, magazine, radio, television, billboard, and MCO yellow page advertisement, [~~and~~] press releases, telephone scripts, web site and presentation materials used by an MCO, [~~and~~] an MCO representative or an MCO sub-contractor to attract and retain SCI enrollment. HSD may request, review and approve or disapprove any communication to any SCI member. HSD may request, review and approve or disapprove any communication to any SCI member regarding behavioral health. [~~MCOs are~~] The MCO is not restricted by HSD in their general communications to the public. HSD shall approve advertisements mailed to, distributed to, or aimed at SCI members and marketing material that mentions SCI, medicaid, medical assistance, Title XIX , Title XXI or Salud! or makes reference to medicaid behavioral health services. The MCO shall notify HSD of significant format changes to advertisements. Examples of medicaid-specific materials would be those that:

(1) are in any way targeted to SCI populations, such as billboards or bus posters disproportionately located in low-income neighborhoods; or

(2) contain language or information designed to attract SCI enrollment.

C. **Advertising and marketing material:** Medicaid-specific advertising and marketing materials, including materials disseminated by a sub-contractor and information disseminated via the internet requires HSD approval. In reviewing this information, HSD shall apply a variety of criteria.

(1) **Accuracy:** The content of the material shall be accurate. Information deemed inaccurate shall be disallowed.

(2) **Misleading references:** Misleading information about the MCO shall not be allowed even if it is accurate.

D. **Marketing and outreach activities not permitted:** The following marketing and outreach activities are not permitted regardless of the method of communication (oral, written or other means of communication) or whether the activity is performed by the MCO directly, its network providers, its subcontractors or any other party affiliated with the MCO. HSD may prohibit additional marketing activities at its discretion.

(1) asserting or implying that a member will lose SCI benefits if he does not enroll with the MCO or creating other scenarios that do not accurately depict the consequences of choosing a different MCO;

(2) designing a marketing or outreach plan that discourages or encourages MCO selection based on a potential member's health status or risk;

(3) making inaccurate, misleading or exaggerated statements designed to recruit a potential member;

(4) asserting or implying that the MCO offers unique covered services when another MCO provides the same or similar services;

(5) the use of more than nominal gifts, such as diapers, toasters, infant formula or other incentives to entice members to join a specific health plan;

(6) telemarketing or other cold call marketing with potential members;

(7) conducting any other marketing activity prohibited by HSD;

(8) explicit direct marketing to members enrolled with other MCOs unless the member requests the information;

(9) distributing any marketing materials without first obtaining HSD approval;

(10) seeking to influence enrollment in conjunction with the sale or offering of any private insurance except in the instance of combination groups that offer commercial coverage and SCI to those employees who may qualify;

(11) engaging in telephone or other cold call marketing activities, directly or indirectly; and

(12) other requirements specified by HSD.

E. **Marketing in current care sites:** Promotional materials may be made available to members and potential MCO enrollees in care delivery sites, including patient waiting areas, if HSD has prior approved the content. Face-to-face meetings with MCO staff, at health care delivery sites, for the purpose of marketing to potential enrollees shall not be permitted.

F. **Provider communications with medicaid members about MCO options:** HSD marketing restrictions shall apply to MCO subcontractors and providers as well as to the MCO. MCOs are required to notify participating providers of the HSD marketing restrictions, including providing a copy of these regulations. HSD shall not review yellow page ads of individual providers, unless specifically requested to do so.

G. **Member-initiated meetings with MCO staff prior to enrollment:** Face-to-face meetings requested by members are permitted. These meetings may occur at a mutually agreed upon site.

H. **Mailings by the MCO:** MCO mailings shall be permitted in response to member oral or written requests for information. The content of marketing or promotional mailings shall be approved by HSD. MCOs may, with HSD approval, provide potential members with information regarding the MCO/SCI benefit package. MCOs shall not send gifts, however nominal in value, in these mailings. MCOs may send solicited and unsolicited mailings to members and potential members. Unsolicited mailings are defined as: newsletters; notification of outreach events and member services meetings; educational materials and literature related to the MCO preventive medicine initiatives, (such as, diabetes screening, drug and alcohol awareness, and mammograms). HSD shall approve the content of mailings except health education materials. The target audience of the mailings shall be approved by HSD.

I. **Group meetings:** The MCO may hold public meetings. HSD shall be furnished with notice of the meetings and shall prior approve marketing material to be presented at the meeting. HSD shall approve the methodology used by the MCO to solicit attendance for the public meetings. HSD may attend the meeting.

J. **Light refreshments for members at meetings:** The MCO may offer light refreshments at approved group meetings. The availability of food and beverages shall not be mentioned in advertisements for the meetings. *Alcoholic beverages shall not be offered at meetings.*

K. **Gifts, cash incentives or rebates to potential members:** MCOs and their providers, with HSD approval, may disseminate marketing materials, including nominal gifts such as pens, key chains and magnets to potential members.

L. **Gifts to members at health milestones unrelated to enrollment:** Members may be given "rewards" for accessing care, such as a baby T-shirt when a woman completes a targeted series of prenatal visits. Items that reinforce a member's healthy behavior, (car seats, infant formula, magnets and telephone labels) that advertise the member services hotline and the PCP office telephone number for members are examples of "rewards". HSD shall approve gifts with a retail value of over $25.00. Health education videos may be provided. HSD encourages MCOs to include reward items in information sent to new MCO members.

M. **Marketing time frames:** The MCO may initiate marketing and outreach activities at any time.

[8.306.5.14 NMAC - N, 7-1-05; A/E, 8-1-07; A, 6-1-08; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.306.6 NMAC, Sections 8, 9 and 12, which will be effective July 1, 2009.

8.306.6.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their community.

[8.306.6.8 NMAC - N, 7-1-05; A, 7-1-09]

8.306.6.9 GENERAL NETWORK REQUIREMENTS: The MCO shall establish and maintain a comprehensive network of providers willing and capable of serving members enrolled with the MCO.

A. **Service coverage:** The MCO shall provide or arrange for the provision of services described in 8.306.7 NMAC, *Benefit Package* prior to contract start date. The MCO is solely responsible for the provision of covered services and shall ensure that its network includes providers in sufficient numbers and required specialists to make all services included in the package available and in accordance with access standards as specified herein and in 8.305.8.18 NMAC, [~~*Medicaid Managed Care Quality Management Standards for Access*~~] *standards for access*.

B. **Comprehensive network:** The MCO shall contract with the full array of providers necessary to deliver a level of care at least equal to, or better than, community norms. The MCO shall contractually require that all network providers and subcontractors be in compliance with the Health Insurance Portability and Accountability Act (HIPAA). In establishing and maintaining the network of appropriate providers, the MCO shall consider the following:

(1) the numbers of network providers who are not accepting new SCI members, as identified by a process for checking the open/closed panel status;

(2) the geographic location of providers and SCI members, considering distance, travel time, the means of transportation ordinarily used by SCI members; and

(3) whether the location provides physical access for SCI members, including members with disabilities.

C. **Maintenance of provider network:** The MCO shall notify HSD within five working days of unexpected changes to the composition of its provider network that negatively affects members' access or the MCO's ability to deliver services included in the benefit package in a timely manner. The MCO shall regularly update open and closed panel status and post this information on its website. Anticipated material changes in an MCO provider network shall be reported to HSD in writing when the MCO knows of the anticipated change or within 30 calendar days, whichever comes first. A notice of significant change shall contain:

(1) the nature of the change;

(2) how the change effects delivery of or access to covered services; and

(3) the MCO's plan for maintaining access and the quality of member care.

D. **Required policies and procedures:** The MCO shall maintain poli-

cies and procedures on provider recruitment and termination of provider participation with the MCO. The recruitment policies and procedures shall describe how an MCO responds to a change in the network that affects access and its ability to deliver services in a timely manner. The MCO:

(1) shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;

(2) shall not discriminate against providers with respect to participation, reimbursement, or indemnification for any provider acting within the scope of that provider's license or certification under applicable state law solely on the basis of the provider's license or certification;

(3) shall not decline to include individual or groups of providers in its network without giving the affected providers written notice of the reason for its decision;

(4) shall not be required to contract with providers beyond the number necessary to meet the needs of its members;

(5) shall be allowed to use different reimbursement amounts for different specialties or for different practitioners within the same specialty;

(6) shall be allowed to establish measures that are designed to maintain quality of services and control costs and are consistent with its responsibility to members;

(7) may not employ or contract with providers excluded from participation in federal health care programs because of misconduct; and

(8) shall not be required to contract with providers who are ineligible to receive reimbursement under medicaid fee-for-service.

E. **General information submitted to HSD:** The MCO shall maintain an accurate list of contracted, subcontracted, pending and terminated PCPs, specialists, hospitals and other providers participating or affiliated with the MCO. The MCO shall submit the list to HSD on a monthly basis and include a clear delineation of all additions and terminations that have occurred since the last submission.

[8.306.6.9 NMAC - N, 7-1-05; A, 7-1-09]

8.306.6.12 PRIMARY CARE PROVIDERS: The primary care provider (PCP) shall be a participating MCO medical provider who has the responsibility for supervising, coordinating and providing primary health care to members, initiating referrals for specialist care and maintaining the continuity of the member's care. The MCO shall distribute information to the providers explaining the SCI-specific policies and procedures outlining PCP responsibilities.

A. **Primary care responsibilities:** The MCO shall ensure that the following primary care responsibilities are met by the PCP or in another manner:

(1) 24-hour, seven day a week access to care;

(2) coordination and continuity of care with providers who participate within the MCO network and with providers outside the MCO network according to MCO policy;

(3) maintenance of a current medical record for the member, including documentation of services provided to the member by the PCP and specialty or referral services;

(4) requiring PCPs contracted with the MCO to vaccinate members in their offices and not refer members elsewhere for immunizations;

(5) ensuring the member receives appropriate prevention services for his age group;

(6) following MCO established procedures for coordination of services for members with providers participating in the MCO network; and

(7) the MCO shall develop and implement policies and procedures governing how coordination with the PCP will occur with hospitals that require in-house staff to examine or treat members having outpatient or ambulatory surgical procedures performed.

B. **Types of primary care providers:** The MCO may designate the following providers as PCPs, as appropriate:

(1) medical doctors or doctors of osteopathic medicine with the following specialties: general practice, family practice, internal medicine, gerontology, obstetrics, and gynecology;

(2) certified nurse practitioners, certified nurse midwives and physician assistants;

(3) specialists, on an individualized basis for members whose care is more appropriately managed by a specialist, such as members with infectious diseases, chronic illness or a disability;

(4) primary care teams consisting of residents and a supervising faculty physician for contracts with teaching facilities or teams that includes certified mid-level practitioners who, at the member's request, may serve as
the point of first contact; in both instances, the MCO shall organize its teams to ensure continuity of care to members and shall identify a "lead physician" within the team for each member; the "lead physician" shall be an attending physician (medical students, interns and residents cannot serve as the "lead physician"); or

(5) other providers who meet the MCO credentialing requirements as a PCP.

C. **Providers that shall not be excluded as PCPs:** MCOs shall not exclude providers as primary care providers based on the proportion of high-risk patients in their caseloads.

D. **Selection or assignment to a PCP:** The MCO shall maintain written policies and procedures governing the process of member selection of a PCP and requests for a change in PCP.

(1) **Initial enrollment:** At the time of enrollment into the MCO, the MCO shall ensure that each member may choose a PCP within a reasonable distance from the member's residence.

(a) The MCO shall assume responsibility for assisting members with PCP selection.

(b) The process whereby the MCO assigns members to PCPs shall include at least the following features:

(i) the MCO shall contact the member within five business days of enrollment and provide information on options for selecting a PCP;

(ii) the MCO shall offer freedom of choice to members in making a selection;

(iii) a member shall choose a PCP or the MCO will assign a PCP within 15 calendar days of enrollment with the MCO; a member may select a PCP from the information provided by the MCO; a member may choose a PCP anytime during this selection period;

(iv) the MCO shall notify the member in writing of his PCP's name, location and office telephone number; and

(v) the MCO shall provide the member with an opportunity to select a different PCP if he is dissatisfied with assigned PCP.

(2) **Subsequent change in PCP initiated by member:** Members may initiate a PCP change at any time, for any reason. The request for PCP change may be made in writing or by telephone. If the change is requested by the 20th day of the month it will become effective the first day of the following month. If the request is made after the 20th day it will become effective the first day of the second month following the request.

(3) **Subsequent change in PCP initiated by the MCO:** In instances where a PCP has been terminated or suspended for potential quality or fraud and abuse issues, the MCO shall allow affected members to select another PCP or make an assignment within 15 days of the termination effective date. The MCO shall notify the member in writing of the PCP's name, location and office telephone number. The MCO may initiate a PCP change for a member under certain circumstances such as:

(a) the member and MCO agree that assignment to a different PCP in the

MCO is in the member's best interest, based on the member's medical condition;

(b) a member's PCP ceases to participate in the MCO's network;

(c) a member's behavior toward the PCP is such that it is not feasible to safely or prudently provide medical care and the PCP has made all reasonable efforts to accommodate the member; or

(d) a member has initiated legal action against the PCP.

(4) **Provider lock-in:** HSD shall allow the MCO to require that a member see a certain provider while ensuring reasonable access to quality services when identification of utilization of unnecessary services or a member's behavior is detrimental or indicates a need to provide case continuity. Prior to placing a member on provider lock-in, the MCO shall inform the member of the intent to lock-in, including the reasons for imposing the provider lock-in and that the restriction does not apply to emergency services furnished to the member. The MCO's grievance procedure shall be made available to a member disagreeing with the provider lock-in. The member shall be removed from provider lock-in when the MCO has determined that the utilization problems or detrimental behavior have ceased and that recurrence of the problems is judged to be improbable. HSD shall be notified of provider lock-ins on a quarterly basis and informed of provider lock-in removals at the time they occur.

(5) Pharmacy lock-in: HSD shall allow the MCO to require that a member see a certain pharmacy provider when member compliance or drug seeking behavior is suspected. Prior to placing the member on pharmacy lock-in, the MCO shall inform the member or his/her representative of the intent to lock-in. The MCO's grievance procedure shall be made available to the member being designated for pharmacy lock-in. The pharmacy lock-in shall be reviewed and documented by the MCO and reported to HSD every quarter. The member shall be removed from pharmacy lock-in when the MCO has determined that the compliance or drug seeking behavior has been resolved and the recurrence of the problem is judged to be improbable. HSD shall be notified of all lock-in removals.

E. **MCO responsibility for PCP services:** The MCO shall be responsible for monitoring PCP actions to ensure compliance with MCO and HSD policies. The MCO shall ensure that PCPs are successfully identifying and referring members to specialty providers as medically necessary.

[8.306.6.12 NMAC - N, 7-1-05; A, 6-1-08; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.306.7 NMAC, Sections 8, 11, 12 and 13, which will be effective July 1, 2009.

8.306.7.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their community.

[8.306.7.8 NMAC - N, 7-1-05; A, 7-1-09]

8.306.7.11 SERVICES INCLUDED IN THE SCI BENEFIT PACKAGE: The SCI benefit package includes provider and consultation services and supplies that are reasonably required to maintain good health and are provided by or under the direction of the member's PCP. The following lists covered services and provides additional information.

A. **Provider services:**

(1) office visits;

(2) home visits;

(3) hospital and inpatient physical rehabilitation facility visits by physician;

(4) inpatient and outpatient surgery (includes assistant surgeon's charges);

(5) office procedures;

(6) inpatient professional care services, including pathologists, radiologists and anesthesiologists;

(7) allergy testing;

(8) allergy injections;

(9) antigen serum;

(10) injections in accordance with accepted medical practice to treat acute conditions, which are customarily administered in a provider's office;

(11) injections in accordance with acceptable medical practice used to treat chronic conditions, including, but not limited to, diseases such as rheumatoid arthritis, crohn's disease, and hepatitis C; and

(12) routine and diagnostic x-rays and clinical laboratory tests.

B. **Inpatient hospital services:** The benefit package includes inpatient hospital services as detailed below.

(1) Hospital admissions must have prior authorization and are to be provided under the direction of the member's PCP or a consulting provider to whom the member is referred by his PCP. Any service or procedure not outlined below requires a prior authorization.

(2) Inpatient hospitalization coverage is limited to [~~twenty-five (25)~~] 25 days per benefit year. This [~~twenty-five (25)~~] 25-day limitation is combined with home health services and inpatient physical rehabilitation.

(3) Inpatient hospital services include:

(a) semi-private room and board accommodations, including general duty nursing care;

(b) private room and board accommodations when medically necessary; prior authorization is required;

(c) in-hospital therapeutic and support care, services, supplies and appliances, including care in specialized intensive and coronary care units;

(d) use of all hospital facilities, including operating, delivery, recovery, and treatment rooms and equipment;

(e) laboratory tests, x-rays, electrocardiograms (EKGs), electroencephalograms (EEGs), and other diagnostic tests performed in conjunction with a member's admission to a hospital;

(f) anesthetics, oxygen, pharmaceuticals, medications, and other biological;

(g) dressings, casts, and special equipment when supplied by the hospital for use in the hospital;

(h) inpatient meals and special diets;

(i) inpatient radiation therapy or inhalation therapy;

(j) rehabilitative services - physical, occupational, and speech therapy;

(k) administration of whole blood, blood plasma, and components;

(l) discharge planning and coordination of services; and

(m) maternity care.

C. **Outpatient services:** The benefit package includes outpatient services performed in a hospital or other approved outpatient facility. Outpatient services:

(1) can reasonably be provided on an ambulatory basis;

(2) are preventive, diagnostic or treatment procedures provided under the direction of the member's PCP or a consulting provider to whom the member is referred by the PCP;

(3) require prior authorization, unless otherwise noted; and

(4) the following provides additional information on covered outpatient services and associated co-payments:

(a) surgeries, including use of operating, delivery, recovery, treatment rooms, equipment and supplies, including anesthesia, dressings and medications;

(b) radiation therapy and chemotherapy;

(c) magnetic resonance imaging (MRI);

(d) positron emission tomography (PET) tests;

(e) CT scan;

(f) holter monitors and cardiac event monitors;

(g) routine and diagnostic x-rays, clinical laboratory tests, electrocardiograms (EKGs), and electroencephalograms (EEGs);

(h) cardiovascular rehabilitation; and

(i) rehabilitative services - physical, occupational, and speech therapy; rehabilitative services for short-term physical, occupational, and speech therapies are covered; short-term therapy includes therapy services that produce significant and demonstrable improvement within a two-month period from the initial date of treatment; the member's PCP or other appropriate treating provider to whom the member has been referred shall determine in advance of rehabilitative services that these services can be expected to result in significant improvement in the member's physical condition within a period of two months; requests for rehabilitative services from therapists will not be approved; these services shall be requested by the ordering provider and require a prior authorization.

(i) Extension of short-term therapy beyond the initial two months may be extended for one period of up to two months, contingent on the approval of the MCO's medical director, only if such services can be expected to result in continued significant improvement of the member's physical condition within the extension period. Expectation of significant improvement will be established if the member has complied fully with the instructions for care and has met all therapy goals for the preceding two-month period as documented in the therapy record.

(ii) Therapy services extending beyond the two-month period from the initial date of treatment are considered long-term therapy and are not covered under SCI. Long-term therapy includes treatment for chronic or incurable conditions for which rehabilitative services produce minimal or temporary change or relief. Chronic conditions include, but are not limited to, muscular dystrophy, cerebral palsy, developmental delay, myofascial pain disorders, arthritis, autism, and syndromes of chromosomal abnormalities.

D. **Emergency and urgently needed health services:** The benefit package includes emergency and urgently needed health services. These services are available [~~twenty-four (24)~~] 24 hours a day, seven [~~(7)~~] days a week. The benefit package includes inpatient and outpatient services meeting the definition of emergency services, which shall be provided without regard to prior authorization or the provider's contractual relationship with the MCO. If the services are needed immediately and the time necessary to transport the member to a network provider would mean risk of permanent damage to the member's health, emergency services shall be available through a facility or provider participating in the MCO/SE network or from a facility or provider not participating in the MCO/SE network. Either provider type shall be paid for the provision of services on a timely basis. Emergency services include services needed to evaluate and stabilize an emergency medical or behavioral condition. Post- stabilization care services means covered services, related to an emergency medical or behavioral condition, that are provided after a member is stabilized in order to maintain the stabilized condition. This coverage may include improving or resolving the member's condition if either the MCO has authorized post-stabilization services in the facility in question, or there has been no authorization; and

(1) the hospital was unable to contact the MCO; or

(2) the hospital contacted the MCO but did not get instructions within an hour of the request; the following provides additional information on covered services and required co-payments.

(a) Emergency health services can be provided in or out of the service area. Coverage is provided for trauma services at an appropriately designated trauma center according to established emergency medical services triage and transportation protocols.

(i) Prior authorization is not required for emergency care.

(ii) Coverage for trauma services and all other emergency health services from non-participating providers will continue at least until the member is medically stable, does not require critical care, and can be safely transferred to another facility based on the judgment of the attending participating provider in consultation with the MCO. The MCO may transfer hospitalized members to the care of participating providers as soon as it is medically appropriate. Such members shall be stabilized and the transfer effected in accordance with federal law.

(iii) The member is responsible for charges for non-covered services.

(b) Use of an urgent care center, where available, in or out of the service area for treatment of sudden unexpected acute illness or injury that requires prompt medical attention to prevent jeopardy to the member if such services were not received immediately.

(i) A non-participating urgent care center may be used only if the member cannot reasonably access a participating provider.

(ii) Routine or follow-up medical treatment shall be provided by or through a participating provider.

E. **Women's health services:** The benefit package includes any gynecological examinations or care related to pregnancy, for primary and preventive obstetrics, and gynecological services required as a result of any gynecological examination or condition. Covered women's health services may be obtained from the member's PCP, or a participating women's health care provider or a consulting provider to whom the member has been referred by her PCP. The following lists covered services and provides additional information:

(1) office visits;

(2) low-dose mammography screening for detection of breast cancer;

(3) cytological screening to determine the presence of pre-cancerous or cancerous conditions or other health problems; and

(4) services related to the diagnosis, treatment and appropriate management of osteoporosis.

F. **Prenatal and post-partum care:** Prenatal care includes a minimum of one prenatal office visit per month during the first two trimesters of pregnancy; two [~~(2)~~] office visits per month during the seventh and eight months of pregnancy; and one [~~(1)~~] office visit per week during the ninth month until tremor as medically indicated, provided that coverage for each office visit shall include prenatal counseling and education.

(1) Following delivery of a newborn, a female member is entitled to either:

(a) post-partum care in the home consisting of up to three visits; or

(b) a minimum hospital stay of specified inpatient hours; the choice of either home care or inpatient care will be made based on discussion between the participating provider and the member.

(2) If post-partum home care is elected, the care shall be rendered in accordance with accepted maternal and neonatal physician assessments, and by a home care participating provider who is properly licensed, trained and experienced. A maximum of three home care visits are allowable.

(3) If inpatient care is elected, a mother and her newborn child in a health care facility will be entitled to a minimum stay of 48 hours following a vaginal delivery or 96 hours following a caesarian section.

(4) Non- hospital births - prior authorization is required.

G. **Preventive health services:** The benefit package includes preventive health services. Preventive health services are provided to a member when performed by or under the direction of the member's PCP or a participating provider to

whom the member has been referred by his PCP, and are consistent with the [~~MCO'S~~] MCO's preventive health guidelines. The following lists covered services and provides additional information.

(1) Physical exams, including health appraisal exams, laboratory and radiological tests, hearing and vision screenings, and early detection procedures.

(2) Periodic tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or a fractionated cholesterol level.

(3) Periodic glaucoma eye tests for all persons [~~thirty-five (35)~~] 35 years of age and older.

(4) Periodic stool examination for the presence of blood for all persons 40 years of age or older.

(5) Periodic mammograms for detection of breast cancer as follows: one low dose baseline mammogram for women ages 35 through 39, one low dose mammogram biennially for women ages 40 through 49 and one low dose mammogram annually for women over age 50.

(6) All members may receive an annual consultation to discuss lifestyle behaviors that promote health and well-being. The consultation may include, but not be limited to:

(a) smoking control;

(b) nutrition and diet recommendations;

(c) exercise plans;

(d) lower back protection;

(e) immunization practices;

(f) breast self-examinations;

(g) testicular self-examinations; or

(h) use of seat belts in motor vehicles.

(7) Adult immunizations in accordance with the recommendations of the advisory committee on immunization practices (ACIP).

(8) Periodic colon examination of [~~thirty-five (35) to sixty (60)~~] 35 to 60 centimeters [~~and/or~~] or barium enema for all persons [~~forty-five (45)~~] 45 years of age or older.

(9) Voluntary family planning services.

(10) Insertion of contraceptive devices.

(11) Removal of contraceptive devices.

(12) Surgical sterilization.

(13) Pregnancy termination procedures: The benefit package includes services for the termination of pregnancy and pre or post-decision counseling or psychological services as detailed in 8.325.7 NMAC, *Pregnancy Termination Procedures.*

H. **Dialysis:** The benefit package includes dialysis services. Long-term hemodialysis and continuous ambulatory peritoneal dialysis (CAPD) is provided with a prior authorization and performed by or under the direction of the member's PCP or a consulting provider to whom the member has been referred by his PCP. The member shall advise the MCO of the date the treatment commenced.

I. **Inpatient physical rehabilitation:** The benefit package includes inpatient physical rehabilitation. The following lists covered services and provides additional information.

(1) Inpatient physical rehabilitation services require prior authorization, and services are to be provided under the direction of the member's PCP or a consulting provider to whom the member is referred by his PCP.

(2) Inpatient physical rehabilitation facility coverage is limited to [~~twenty-five (25)~~] 25 days per benefit year. This [~~twenty-five (25)~~] 25-day limitation is combined with inpatient hospital and home health services.

J. **Home health services/home intravenous services:** The benefit package includes home health services, which are health services provided to a member confined to his home due to physical illness. The following lists covered services and provides additional information.

(1) Home health services and home intravenous services are provided by a home health agency (HHA) at a member's home with a prior authorization and prescribed by the member's PCP or a consulting provider to whom the member is referred by his PCP.

(2) Home health services in lieu of hospitalization are limited to [~~twenty-five (25)~~] 25 days per benefit year provided that a period of inpatient hospitalization coverage shall precede any home health care coverage or the PCP shall provide a statement indicating that inpatient hospitalization would be necessary in the absence of home health services. This [~~twenty-five (25)~~] 25 day limitation is combined with inpatient hospitalization and inpatient physical rehabilitation.

(3) Services provided by a registered nurse or a licensed practical nurse; by physical, occupational, and respiratory therapists; speech pathologists; or by a home health aide are covered.

(4) Prescription supplies for the provision of home health services at the time of a home health visit are covered.

(5) Home intravenous services are covered.

(6) Tube feedings as the sole source of nutrition are covered.

K. **Durable medical equipment, medical supplies, orthotic appliances and prosthetic devices:** The benefit package includes durable medical equipment, medical supplies, orthotic appliances, and prosthetic devices. The following lists covered services and provides additional information.

(1) Prior authorization is required.

(2) Durable medical equipment, medical supplies, orthotic appliances and prosthetic devices with allowable charges of $200 or more per item, including tax and any shipping charges are covered. Rental price cannot exceed purchase price.

(3) Durable medical equipment that requires a provider's prescription for purchase or rental is covered unless otherwise excluded.

(4) Medical supplies that require a provider's prescription for purchase are covered unless otherwise excluded.

(5) Orthotic appliances that require a provider's prescription for purchase are covered unless otherwise excluded.

(6) Prosthetic devices are covered only when they replace a limb or other part of the body after accidental or surgical removal or when the body's growth or atrophy necessitates replacement, unless otherwise excluded.

(7) Breast prostheses and bras required in conjunction with reconstructive surgery are covered, except as limited.

(8) Repair or replacement of durable medical equipment, orthotic appliances and prosthetic devices due to normal wear or when necessitated by the body's growth or atrophy are covered.

L. **Ambulance services:** The benefit package includes emergency transport services identified below.

(1) When necessary to protect the life of the mother or infant, emergency transport includes transport for medically high-risk pregnant women with an impending delivery to the nearest tertiary care facility.

(2) The MCO will not pay more for air ambulance than it would have paid for transportation over the same distance by surface emergency medical transportation services unless the member's health condition renders the utilization of such surface services medically inappropriate.

(3) Emergency ground ambulance transportation to the nearest facility where emergency care and treatment can be rendered and when provided by a licensed ambulance service

(4) Emergency, trauma-related air ambulance transportation - prior authorization is required, when feasible.

M. **Oral surgery:** The benefit package includes limited oral surgery benefits with prior authorization. The

following lists covered services and provides additional information. General dental and oral surgery services with a prior authorization only in conjunction with:

(1) Accidental injury to sound natural teeth, the jawbones, or surrounding tissues, treatment for injury is covered when initial treatment for the injury is sought within [~~seventy-two (72)~~] 72 hours of the injury. Teeth with crowns or restorations are not considered to be sound natural teeth. The injury shall be properly documented during the initial treatment. Services shall be completed within [~~twelve (12)~~] 12 months of the date of injury. The MCO will require dental x-rays.

(2) Surgical procedures to correct non-dental, non-maxillomandibular physiologic conditions that produce demonstrable impairment of function are covered.

(3) Removal or biopsy, when pathological examination is required of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth are covered.

(4) External incision and drainage of cellulitis; incision of infected accessory sinuses, salivary glands or ducts; and removal of stones from salivary ducts are covered.

(5) Surgical procedures to correct accidental injuries of the jaws and facial bones, cheeks, lips, tongue, roof and floor of mouth are covered.

N. **Reconstructive surgery:** The benefit package includes reconstructive surgery as provided below.

(1) Reconstructive surgery from which an improvement in physiological function can be expected if performed for the correction of functional disorders - prior authorization is required. Functional disorder shall result from accidental injury or from congenital defects or disease.

(2) Prosthetic devices and reconstruction surgery of the affected breast or other breast to produce symmetry related to mastectomy. This coverage includes physical complications at all stages of mastectomy, including lymph edemas. A member is allowed at least [~~forty-eight (48)~~] 48 hours of inpatient care following mastectomy and [~~twenty-four (24)~~] 24 hours of inpatient care following a lymph node dissection for the treatment of breast cancer.

O. **Prescription drugs:** The benefit package includes all generic prescription drugs and brand name drugs included on the [~~MCO'S~~] MCO's preferred drug list (PDL). Exceptions to the PDL depend on MCO policy.

P. **Diabetes treatment:** The benefit package includes diabetes treatment. The MCO will maintain an adequate PDL to provide resources to members with diabetes; and guarantee reimbursement or coverage for prescription drugs, insulin, supplies, equipment and appliances with a prior authorization described in this subsection within the limits of the MCO. The following lists covered services and provides additional information.

(1) Equipment, supplies and appliances to treat diabetes to include:

(a) blood glucose monitors, including those for the legally blind;

(b) test strips for blood glucose monitors;

(c) visual reading urine and ketone strips;

(d) lancets and lancet devices;

(e) insulin (limit two [~~(2)~~] vials per co-payment);

(f) injection aids, including those adaptable to meet the needs of the legally blind;

(g) syringes;

(h) prescriptive oral agents for controlling blood sugar levels;

(i) medically necessary podiatric appliances for prevention of foot complications associated with diabetes, including therapeutic molded or depth inlay shoes, functional orthotic appliances, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment; and

(j) glucagons emergency kits.

(2) Diabetes self-management training by a certified, registered or licensed health care professional with recent education in diabetes management, which is limited to:

(a) medically necessary visits upon the diagnosis of diabetes;

(b) visits following a provider diagnosis that represents a significant change in the member's symptoms or condition that warrants changes in the member's self-management;

(c) visits when re-education or refresher training is prescribed by a health care provider with prescribing authority; and

(d) medical nutrition therapy related to diabetes management.

Q. **Behavioral health and substance abuse services:** The benefit package includes behavioral health and substance abuse services. Inpatient behavioral health services are limited to [~~twenty-five (25)~~] 25 days per benefit year with prior authorization.

(1) **Behavioral health service:**

(a) Outpatient office visits for mental health evaluation and treatment; injectable forms of haloperidol or fluphenazine are included in the office visit co-payment. Prior authorization is required for over seven (7) visits.

(b) Inpatient mental health services provided in a psychiatric hospital or an acute care general hospital - *prior authorization is required*.

(2) **Substance abuse service:**

(a) outpatient substance abuse including visits, detoxification and intensive outpatient care limited to [~~forty-two (42)~~] 42 days per benefit year; and

(b) inpatient substance abuse detoxification - *prior authorization is required.*

R. **Annual limits on out-of-pocket expenditures:** Out-of-pocket charges for all participants will be limited to 5 percent of maximum gross [~~family~~] household income per benefit year. Pharmacy out-of-pocket charges for all participants will be limited to $12 per month.

S. **Limitations on coverage:** The benefit package is limited to $100,000 in benefits payable per member per benefit year.

T. **Pregnancy termination procedures:** The MCO shall provide coverage of pregnancy termination as allowed per 42 CFR 457.475. Medically necessary pregnancy terminations which do not meet the requirements of 42 CFR 457.475 are excluded from the capitation payment made to the MCO and shall be reimbursed solely from state funds pursuant to the provisions of 8.325.7 NMAC.

[8.306.7.11 NMAC - N, 7-1-05; A, 4-16-07; A, 6-1-08; A, 7-1-09]

8.306.7.12 COVERED SERVICES AND SERVICE LIMITATIONS: The SCI benefit package is limited to $100,000 in benefits payable per member per benefit year. Covered services are subject to the following conditions and limitations:

A. **Medically necessary:** Medically necessary services are clinical and rehabilitative physical, mental or behavioral health services that:

(1) are essential to prevent, diagnose or treat medical conditions or are essential to enable the individual to attain, maintain or regain functional capacity;

(2) are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical, mental and behavioral health care needs of the individual;

(3) are provided within professionally accepted standards of practice and national guidelines; and

(4) are required to meet the physical, mental and behavioral health needs of the individual and are not primarily for the convenience of the individual, the provider or the payer.

B. Behavioral health and substance abuse services:

(1) Inpatient mental health services/partial hospitalizations are limited to [~~twenty-five (25)~~] 25 days per benefit year.

(2) Inpatient substance abuse detoxification is limited to 72 hours per

occurrence as part of the total [~~twenty-five~~] 25 day benefit for inpatient mental health services.

(3) Outpatient substance abuse detoxification services are limited to ten [~~(10)~~] days per benefit year. Substance abuse outpatient services including intensive outpatient services are limited to [~~forty-two (42)~~] 42 days per benefit year.

C. **Cardiovascular rehabilitation:** Coverage for cardiovascular rehabilitation is limited to a maximum of [~~thirty-six (36)~~] 36 sessions per cardiac event.

D. **Choice of provider:** For the purpose of coverage under this policy, the SCI MCO has the right to determine which provider may be used to provide the covered services.

E. **Contact lenses or eyeglasses following cataract surgery:** One complete set of contact lenses or eyeglasses is covered following surgery for the removal of cataracts from one or both eyes. Coverage is not allowed for both contact lenses and eyeglasses. Coverage is limited to one set of contact lenses or eyeglasses per member per surgery. Coverage for materials (contact lenses or eyeglasses) is limited to $300 per surgery. Coverage for contact lenses or eyeglasses is limited to [~~ninety (90)~~] 90 days following surgery for the removal of cataracts. Contact lenses or eyeglasses obtained after the [~~ninety (90)~~] 90 day period are not covered.

F. **Dental services:** In cases of accidental injury to sound natural teeth, the jawbones, or surrounding tissues, treatment for injury is covered when initial treatment for the injury is sought within [~~seventy-two (72)~~] 72 hours of the injury. Teeth with crowns or restorations are not considered to be sound natural teeth. The injury shall be properly documented during the initial treatment. Services shall be completed within [~~twelve (12)~~] 12 months of the date of injury. The MCO will require dental x-rays.

G. **Detoxification:** Inpatient detoxification is limited to [~~seventy-two (72)~~] 72 hours of inpatient services per occurrence as part of the [~~twenty-five~~] 25 day benefit for inpatient behavioral health services. Outpatient detoxification is limited to ten [~~(10)~~] days per benefit year.

H. **Home health services:** Home health services in lieu of hospitalization, or a combination of inpatient hospitalization, home health services and inpatient rehabilitation, may not exceed [~~twenty-five (25)~~] 25 days per benefit year, provided that a period of inpatient hospitalization coverage shall precede any home health care coverage or the PCP shall provide a statement indicating that inpatient hospitalization would be necessary in the absence of home health services. Home health services are subject to periodic review of the continuation of covered services. If home health services can be provided in more than one medically appropriate setting, the MCO may choose the setting for providing the care.

I. **Inpatient hospitalization, home health services, inpatient rehabilitation:** This policy is limited to maximum of [~~twenty-five (25)~~] 25 combined days per member per benefit year for inpatient hospitalization, home health services and inpatient rehabilitation.

J. **Major disasters:** In the event of any major disaster, epidemic, or other circumstance beyond its control, the MCO will render or attempt to arrange covered services with participating providers insofar as practical according to its best judgment and within the limitations of facilities, supplies, pharmaceuticals, and personnel available. Such circumstances include: complete or partial disruption of facilities; war; riot; civil uprising; disability of the MCO personnel; disability of participating providers; or act of terrorism.

K. **Maximum benefit limits:** Maximum benefits allowed under SCI are limited to $100,000 per member per benefit year.

L. **Maternity transport:** Coverage for transportation where medically necessary to protect the life of the infant or mother, including air transport if indicated for medically high risk pregnant women with an impending delivery of a potentially viable infant to the nearest available tertiary care center.

M. **Mastectomy and lymph node dissection:** Length of inpatient stay: not less than [~~forty-eight (48)~~] 48 hours inpatient stay following a mastectomy and not less than [~~twenty-four (24)~~] 24 hours of inpatient care following a lymph node dissection when determined medically appropriate by physician and patient.

N. **Orthotic appliances and prosthetic devices:** Repair or replacement of orthotic appliances and prosthetic devices due to normal wear is covered.

O. **Physical, speech and occupational therapy:** Only short-term rehabilitative services are covered. Short-term therapy is limited to no more than two [~~(2)~~] consecutive months per member per condition.

P. **Post mastectomy supplies:** Bras required in conjunction with reconstructive surgery are limited to two [~~(2)~~] per member, per benefit year.

Q. **Prescription drugs:** Prescription drugs are limited to generic drugs and name brand prescriptions on the preferred drug list (PDL) drugs as listed on the MCO PDL. The MCO shall ensure that Native American members accessing prescription drugs at IHS or tribal 638 facilities will be exempt from the MCO's PDL. For each co-payment amount, quantities are limited to a [~~thirty (30)~~] 30-day supply or [~~one hundred (100)~~] 100 tablets; whichever is less, per prescription or refill. All other units will be dispensed in a [~~thirty (30)~~] 30 -day supply, with one co-payment required for each of the following quantities:

(1) **Topical products:** The lesser of [~~eighty (80)~~] 80 gm. of cream/ointment or [~~sixty (60)~~] 60 ml. of lotion/solution or the most commonly dispensed trade package size, per co-payment.

(2) **Oral liquids:** 480 ml. maximum per co-payment.

(3) **Inhalers and vials:** One [~~(1)~~] co-payment per unit (diabetic insulin exception - two [~~(2)~~] vials of the same type of insulin per co-payment).

(4) **Manufacturer's trade package:** One [~~(1)~~] co-payment per trade package (i.e. imitrex, estrogen patches).

(5) **Mail order drugs** are limited to drugs available through the MCO'S mail order distributor.

R. **Transplants - organ, bone marrow, [~~and/or~~] or tissue:**

(1) Organ, bone marrow, [~~and/or~~] or tissue transplants are limited to:

(a) heart;

(b) heart/lung;

(c) lung;

(d) liver;

(e) cornea;

(f) kidney;

(g) skin;

(h) bone marrow (allogenic and autologous stem cell rescue only for leukemia, aplastic anemia, severe combined immunodeficiency disease, wiskott-aldrich syndrome, advanced hodgkin's or non-hodgkin's lymphoma, recurrent or refractory neuroblastoma, and multiple myelomas); or

(i) pancreas (for uremic, insulin-dependent diabetics concurrently receiving a kidney transplant).

(2) No other transplant procedures are covered. The MCO has the right to require that transplants be performed at contracted centers of excellence if one is available.

(3) A member is eligible for coverage for up to two [~~(2)~~] transplants per lifetime. Multiple organ, bone marrow, [~~and/or~~] or tissue transplants performed at the same time are considered to be one procedure. All transplant services are limited by the $100,000 annual benefit limitation per member per benefit year.

[8.306.7.12 NMAC - N, 7-1-05; A, 7-1-09]

8.306.7.13 SERVICES EXCLUDED FROM THE SCI BENE-

FIT PACKAGE: SCI does not cover any service or supply not specifically listed in 8.306.7.12 NMAC as a covered service. If a service is not a covered service, then all services performed in conjunction with the non-covered service are not covered as well. The list of exclusions below is not intended to be exhaustive. If a service is not listed in 8.306.7.12 NMAC as a covered service, then it is not covered regardless of medical necessity. Other services excluded are:

A. **Services not coordinated through a member's PCP or lack of a prior authorization:** Health services and supplies if not provided by or under the direction of:

(1) the member's PCP or a provider to whom the member has been referred by his PCP;

(2) a non-participating provider to whom the member has been referred by his PCP, and a prior authorization is in place for those services; or

(3) any services or supplies that require a prior authorization if a prior authorization is not obtained.

B. **Services not medically necessary, not standard medical practice, or experimental:** The following services are not covered:

(1) any treatment, procedure, facility, equipment, drug, drug use, device, or supply that is not medically necessary; SCI pays only for medically necessary services furnished by approved providers to eligible recipients; SCI does not cover experimental or investigational medical, surgical, or other health care procedures or treatments, including the use of drugs, biological products, other products or devices except routine patient costs associated with certain Phase I, II III and IV cancer clinical trials;

(2) drugs and devices that are not FDA approved, not FDA approved for the proposed use, or that have been voluntarily removed from the market; and

(3) medical, surgical, [~~and/or~~] or behavioral health procedures, pharmacological regimes, [~~and/or~~] or associated health services if they are experimental, under investigation, or generally not standard medical practice.

C. **Acupuncture and chiropractic services:** Acupuncture and chiropractic services are not covered.

D. **Assistant surgeon services:** Assistant surgeon services are not covered if not approved by the MCO.

E. **Behavioral health:** The following behavioral health services are not covered: behavioral health services that are rendered in connection with disorders not classified in the international classification of diseases, 9th revision, clinical modification (ICD-9-CM). Behavioral health services that are not inpatient hospitalizations or outpatient visits including, but not limited to, residential treatment services, treatment foster care, day treatment, and neurobehavioral programs.

F. **Cosmetic services:** Cosmetic services are not covered, including but not limited to: surgery, services, or procedures to change family characteristics or conditions due to aging; dermabrasion; scar reconstruction or revision; acne surgery (including excision of scarring and cryotherapy); tattoo removal; orthognathic jaw surgery; services performed in connection with the enlargement, reduction, implantation, or change in appearance of a portion of the body; surgical excision or reformation of sagging skin on any part of the body including, but not limited to eyelids, face, neck, abdomen, arms, legs or buttocks; microphlebectomy; sclerotherapy; liposuction; rhinoplasty; otoplasty; services related to a cosmetic service, or required as a result of a noncovered cosmetic service; surgery required as a result of a noncovered procedure (such as a noncovered organ/tissue transplant or a sex change operation) or additional surgery or treatment required to care for or correct a complication due to a previous cosmetic service; or breast augmentation, reduction mammoplasty, or nipple reconstruction except as related to reconstructive surgery.

G. **Court ordered care:** Court-mandated evaluations and treatment that would not be in compliance with the terms and conditions of the MCO contract are not covered.

H. **Coverage out of the service area:** Coverage while away from service area, except for emergency health services and urgently needed health services, is not included unless otherwise covered.

I. **Custodial care:** Custodial or home (domestic) care, including services and supplies that can be performed by non-licensed medical personnel to help a member meet the normal activities of daily living are not covered. Examples of custodial care that are not covered services are:

(1) bathing;

(2) feeding;

(3) preparing meals; and

(4) performing housekeeping tasks.

J. **Dental services:** The following dental services are not covered:

(1) All general dental services and dental x-rays, including but not limited to:

(a) anesthesia and facility services for dental restoration;

(b) removal of impacted teeth;

(c) removal of tori or exostoses;

(d) procedures involving orthodontic care, the teeth, dental implants and periodontal disease;

(e) artificial devices, surgery on the supporting structures of the teeth, and bone grafts to prepare the mouth for denture wear;

(f) personalized restorations, cosmetic replacement of serviceable restorations, or materials that are more expensive than necessary to restore damaged teeth; or

(g) surgical realignment of the jaw structures for functional malocclusion.

(2) Orthodontics, endodontics, and dental prosthetics.

(3) Orthotic and orthodontic appliances [~~and/or~~] or treatment, crowns, bridges, [~~and/or~~] or dentures used for the treatment of craniomandibular and temporomandibular joint disorders.

K. **Donor services:** Medical and hospital services of a donor when the recipient of an organ, bone marrow, [~~and/or~~] or tissue transplant is not a member, or when the transplant procedure is not a covered service are not included in the benefit package.

L. **Durable medical equipment, medical supplies; prosthetic devices; orthotic appliances:** The following are not included in the benefit package:

(1) **Durable medical equipment, medical supplies:**

(a) equipment that is non-medical in nature such as voice synthesizers or other communication devices, waterbeds, jacuzzi units, hot tubs, whirlpools, swimming pools, exercise equipment, heating pads, or hot water bottles;

(b) air conditioners, humidifiers, purifiers, or self-help devices, biofeedback equipment, and tens units;

(c) deluxe equipment, such as motor-driven wheelchairs, chairlifts, or beds, when standard equipment is available and adequate to meet functional requirements;

(d) repairs to equipment that is not owned by the member, or repairs to equipment that exceeds the rental price of another unit for the estimated period of need or that exceeds the purchase price of a new unit;

(e) comfort or safety items such as bed boards, hospital beds or mattresses, flotation mattresses, bathtub lifts, grab bars, over bed tables, adjustable beds, telephone arms, diapers, under pads;

(f) sphygmomanometers, stethoscopes, and blood pressure monitors; or

(g) medical supplies and equipment that can be purchased over the counter such as shower chairs, elevated toilet seats, alcohol pads, and dressing supplies.

(2) **Prosthetic devices:**

(a) prosthetic devices unless they replace a limb or other part of the body after accidental or surgical removal [~~and/or~~] or when the body's growth or atrophy necessitates replacement;

(b) external prosthetic devices

that are suited for heavier physical activity such as fast walking, jogging, bicycling, or skiing;

(c) cosmetic coverings for external prosthetic devices;

(d) repairs of prosthetic devices that are not owned by the member; or

(e) cochlear implants.

(3) **Orthotic appliances:**

(a) accommodative orthotic appliances; orthopedic shoes and shoe orthotic appliances (except when the shoes are attached and an integral part of the brace), arch supports, shoe inserts, special-ordered shoes, custom shoes, built up shoes of any type, and other supportive devices for the feet, except for the management of diabetes as required by law;

(b) orthopedic appliances that can be purchased over-the-counter;

(c) cranial banding services; or

(d) penile prosthesis.

M. **Eyeglasses and vision services:** The following eyeglasses and vision services are not included in the benefit package:

(1) eye refractions, eyeglasses, and contact lenses, [~~and/or~~] or the fitting thereof, and routine vision services, except for contact lenses or eyeglasses following cataract surgery; and

(2) surgical procedures for the correction of visual acuity in lieu of eyeglasses or contact lenses, except for intraocular lenses in connection with cataract removal.

N. **Genetic testing:** Genetic testing, screening (other than by triple serum test only) and counseling, with the exception of genetic testing for the diagnosis or treatment of a current illness are not included in the benefit package.

O. **Health clubs:** Fees for health clubs, spas and exercise programs are not included in the benefit package.

P. **Hearing aids:** The purchase of hearing aids, [~~and/or~~] or the fitting thereof, associated hearing aid testing, and other artificial aids, is not included except as specifically defined in subsection G of 8.306.7.11 NMAC, *preventive health services*.

Q. **Hospice care:** Hospice care is not included in the benefit package.

R. **Illegal acts or crimes:** The following is not covered: Injury or illness sustained during the voluntary participation in a riot or the commission of an illegal act or crime, or while under the influence of alcohol or other drug or controlled substance, which is not prescribed by a provider. For purposes of this Subsection, a person will be presumed to be under the influence of alcohol or other drug or controlled substance if objective evidence suggests such condition, as determined pursuant to the reasonable exercise of discretion by the MCO. The limitations of this subsection will not apply unless there is a direct causal relationship between the activity described above and the illness or injuries sustained.

S. **Infertility treatment:** Infertility treatment services are not covered.

T. **Learning disorders:** Special education, counseling, therapy, diagnostic testing, or treatment for learning disorders, whether or not associated with a mental disorder, retardation, or other disturbance, are not included in the benefit package.

U. **Marital therapy or counseling:** Marital therapy or counseling is not covered.

V. **Missed appointments:** Costs incurred in conjunction with missed appointments are not included in the benefit package.

W. **Modifications, improvements, equipment:** Home, workplace, and automobile modifications, improvements, or equipment are not included in the benefit package.

X. **No legal obligation to pay:** The following are not included in the benefit package:

(1) services a member is eligible to receive and has received under any governmental program which, in the absence of any health services or insurance plan, no charge would be made to the member; and

(2) services or supplies for which the member has no legal obligation to pay or for which no charge would be made if the member were not eligible for SCI.

Y. **Paternity tests:** Diagnostic tests to establish paternity of a child or unborn child are not included in the benefit package.

Z. **Physical examinations:** The following physical examinations are not included in the benefit package:

(1) routine physical examinations, vaccinations, [~~and/or~~] or immunizations if given for:

(a) the purpose of obtaining employment, insurance, passports, or travel; or

(b) for the purpose of medical research.

(2) sports and school physicals, unless done in conjunction with periodic health assessments.

AA. **Physical, speech, occupational therapy - long term:** All long-term physical, speech and occupational therapy services are not included in the benefit package.

BB. **Physical, speech, occupational therapies:** Physical, speech, occupational therapies for the following conditions are not covered:

(1) psychosocial speech delay including delayed language development and developmental apraxia;

(2) mental retardation, down's syndrome, autism, autism spectrum disorders, or dyslexia;

(3) syndromes associates with diagnosed disorders attributed to perceptual and conceptual dysfunctions;

(4) learning disabilities, developmental articulation and language disorders, and stuttering; and

(5) sensory disorders (oral and tactile aversions).

CC. **Podiatry and foot care:** The benefit package does not include podiatry or foot care, including but not limited to: bunion treatment, callus treatment, corn paring or excision, toenail trimming, except in the treatment of insulin-dependent diabetics. Foot massage of any type, treatment of fallen arches, flat or pronated feet, and shock wave treatment are not included in the benefit package.

DD. **Prenatal, delivery, post-partum services:**

(1) **All services related to the prenatal period:** Delivery and post-partum services shall be received in the MCO service area with the exception of a pregnant woman in the third trimester of pregnancy who has an established relationship with an obstetrical provider and desires to continue that relationship, and the provider is not participating with the MCO.

(2) Tests to determine the gender of an unborn child are excluded from coverage.

EE. **Prescription drugs:** The following are excluded from coverage:

(1) brand name non-PDL prescription drugs without prior approval;

(2) drugs that do not require a physician's prescription; except insulin;

(3) contraceptive jellies, creams, foams, devices or implants (except legend contraceptive devices);

(4) therapeutic devices or appliances;

(5) drugs whose sole purpose is to promote or stimulate hair growth (e.g., Rogaine®, Propecia®) or for cosmetic purposes only (e.g., Renova®);

(6) biologicals, blood or blood plasma products;

(7) drugs labeled "caution - limited by federal law to investigational use" or experimental drugs, even though a charge is made to the individual;

(8) medication for which the cost is recoverable under any workers' compensation or occupational disease law or from any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to

the member;

(9) medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution, which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals;

(10) any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order; and

(11) charges for the administration or injection of any drug.

FF. **Pulmonary rehabilitation:** Pulmonary rehabilitation is not included in the benefit package.

GG. **Recovery:** Services and supplies that are otherwise covered, to the extent that a member realizes a recovery from any source, are not included in the benefit package.

HH. **Repair or replacement for lost, stolen, or damaged items:** Repair or replacement for lost, stolen, or damaged items listed below are not included in the benefit package:

(1) durable medical equipment;

(2) medical supplies;

(3) orthotic appliances;

(4) prosthetic devices; and

(5) prescription drugs.

II. **Services, supplies for excluded services:** Services, supplies, or drugs used for non-covered or excluded procedures or treatment, or used for any related complication(s) are not included in the benefit package.

JJ. **Services, supplies not primarily medical:** Services, supplies, and self-help items that are not primarily medical in nature, for personal comfort or safety, convenience or beautification during an inpatient stay, or in the home setting are not covered. Examples include but are not limited to: facial tissues, shampoo, diapers, under pads, grab bars, and exercise equipment.

KK. **Sex transformation:** Sex transformation surgery and all expenses in connection with such surgery are not included in the benefit package.

LL. **Sexual dysfunction:** Treatment for sexual dysfunction, including medication, counseling, and clinics, is not included in the benefit package.

MM. **Sterilization reversal:** Any service related to reversal of sterilization is not included in the benefit package.

NN. **Substance abuse [~~and/or~~] or tobacco use:** Treatment to prevent the following is not included in the benefit package:

(1) inpatient substance abuse treatment other than detoxification; and

(2) nicotine medications, gums, services, or supplies to aid in the treatment of addiction to tobacco or tobacco products; nicotine withdrawal treatments, including hypnosis, biofeedback, guided imagery, and other forms of relaxation training or subliminal suggestions used to modify tobacco use.

OO. **Therapies:** Therapies including, but not limited to: exercise, massage, hypnotherapy, sensory, hippo, aquatic, oral aversion, visual training, recreational, sleep, stress management, scream, and myotherapy are not included in the benefit package.

PP. **Travel/lodging expenses:** Travel and lodging expenses are not included in the benefit package.

QQ. **Vocational rehabilitation services:** Vocational rehabilitation services are not included in the benefit package.

RR. **War, terrorism, armed forces:** Any illness [~~and/or~~] or injury resulting from war, act of terrorism, or an act of war or service in the armed forces of any country are not included in the benefit package, to the extent covered services of such illness [~~and/or~~] or injury are provided through any governmental plan or program.

SS. **Weight loss:** Surgery, medications, and related services for the purpose of weight reduction or control are not included in the benefit package.

TT. **Worker's compensation:** Industrial, work-related, or occupational illnesses, injuries, or conditions subject to federal, state, or other workers' compensation or liability law or other legislation of similar purpose are not included in the benefit package, unless the group is an employer not subject to the New Mexico Workers' Compensation Act or similar legislation.

UU. **Miscellaneous:** The following miscellaneous items are not included in the benefit package:

(1) charges associated with copying or transferring of health information;

(2) consultations by environmental engineers;

(3) devices, medications, and treatments to remove hair due to excessive hair growth;

(4) holistic medicine [~~and/or~~] or biofeedback;

(5) treatments, medications, prosthetic devices, and orthotic appliances to treat hair loss;

(6) bone density screening with ultrasound devices; and

(7) telephone visits by a provider or environmental intervention or consultation by telephone for which a charge is made to the member, and getting acquainted visits without physical assessment or diagnostic or therapeutic intervention provided.

[8.306.7.13 NMAC - N, 7-1-05; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.306.8 NMAC, Sections 8, 9 and 10, which will be effective July 1, 2009.

8.306.8.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their community.

[8.306.8.8 NMAC - N, 7-1-05; A, 7-1-09]

8.306.8.9 QUALITY MANAGEMENT: [~~HSD recognizes that strong programs of quality improvement and assurance help ensure that better care is delivered in a cost effective manner to the member. Under the terms of the medicaid managed care contracts, quality management programs are incorporated into health care delivery and administrative systems.~~] Quality management is both a philosophy and a method of management designed to improve the quality of services; includes both quality assurance and quality improvement activities; and, is incorporated into health care delivery and administrative systems. SCI prefers, but does not require NCQA accreditation for MCOs. The SCI program will require compliance with portions of 8.305.8 NMAC, *Quality Management,* as they apply to the SCI adult (19-64) population, as follows: 8.305.8.10 NMAC, *external quality review*; 8.305.8.11 NMAC, *broad standards*; 8.305.8.12 NMAC, *standards for quality management and improvement*; 8.305.8.13 NMAC, *standards for utilization management*; 8.305.8.14 NMAC, *standards for credentialing and recredentialing*; 8.305.8.15 NMAC, *member bill of rights*; 8.305.8.16 NMAC, *standards for preventive health services*; with the exception of Paragraph 13 and 14 of Subsection C of 8.305.8.16 NMAC, *newborn screening and tot-to-teen health checks*; 8.305.8.17 NMAC, *standards for medical record*; and 8.305.8.18 NMAC, *standards for access*.

[8.306.8.9 NMAC - N, 7-1-05; A, 7-1-09]

8.306.8.10 DELEGATION: Delegation is a process whereby an MCO gives another entity the authority to perform certain functions on its behalf. The MCO is

fully accountable for all delegated activities and decisions made. The MCO shall document its oversight of the delegated activity. The MCO, if contractually obligated, shall delegate behavioral health functions and activities, which may include: quality oversight, utilization management prevention, education, outreach, grievance resolution, data collection and claims payment to the contracted single statewide entity (SE).

A. A mutually agreed upon document between the MCO and the delegated entity will describe:

(1) the responsibilities of the MCO and the entity to which the activity is delegated;

(2) the delegated activity;

(3) the frequency and method of reporting to the MCO;

(4) the process by which the MCO evaluates the delegated entity's performance; and

(5) the remedies up to, and including, revocation of the delegation, available to the MCO if the delegated entity does not fulfill its obligations.

B. The MCO shall document evidence that the MCO:

(1) evaluated the delegated entity's capacity to perform the delegated activities prior to delegation;

(2) evaluates regular reports; and

(3) evaluates semi-annually the delegated entity's activities in accordance with the MCO's expectations and HSD standards.

[8.306.8.10 NMAC; A, 7-1-05; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.306.10 NMAC, Sections 8, 11 and 12, which will be effective July 1, 2009.

8.306.10.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their community.

[8.306.10.8 NMAC - N, 7-1-05; A, 7-1-09]

8.306.10.11 ENCOUNTER SUBMISSION TIME FRAMES: The MCO shall submit encounter data to HSD within 120 days of the service delivery date, payment date or discharge as defined by HSD. HSD shall establish error thresholds, time frames and procedures for the submission, correction and resubmission of encounter data.

[8.306.10.11 NMAC - N, 7-1-05; A, 7-1-09]

8.306.10.12 ENCOUNTER DATA ELEMENTS: Encounter data elements are [~~based on HIPAA compliant formats developed by CMS and HSD for use in managed care~~] a combination of those elements required by HIPAA-compliant transaction formats, which comprise a minimum core data set for states and MCOs and those required by CMS or HSD for use in managed care. Encounter data elements are specified in the medicaid systems manual. [~~The human services department~~] HSD may increase or reduce or make mandatory or optional, data elements as it deems necessary.

[8.306.10.12 NMAC - N, 7-1-05; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.306.11 NMAC, Sections 8 and 9, which will be effective July 1, 2009.

8.306.11.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their community.

[8.306.11.8 NMAC - N, 7-1-05; A, 7-1-09]

8.306.11.9 REIMBURSEMENT:

A. MCO and HSD shall comply with 8.305.11.9 NMAC, *reimbursement for managed care,* for the SCI program with the exception of SCI members who are hospitalized at the time of disenrollment from SCI (see below Subsection B of 8.306.11.9 NMAC). Rates negotiated between HSD and the MCO are considered confidential.

B. **SCI members who disenroll while hospitalized:** If the member is hospitalized at the time of disenrollment from SCI, or upon an approved switch from one SCI contractor to another, the contractor at the time of admission remains responsible for all covered or approved services until the earliest of: the date of discharge, date of switch to another contractor, date of the member's termination/disenrollment or until the maximum benefit limits are reached.

[~~B.~~] C. **Payment of premiums:** In addition to capitation payments from HSD, the MCO shall receive premium payments as specified by HSD. Premiums will be paid as follows:

(1) **employer premium** amount determined by department; and

(2) **employee or individual premium** determined by department based on the federal poverty limits as follows: 0-100[~~%~~] percent per month, 101-150[~~%~~] percent per month, 151-200[~~%~~] percent per month,

[~~C.~~] D. **Premium timeframes:** Initial premiums are due to the MCO immediately upon enrollment and prior to the 1st day of the month before coverage begins. An employer group or individual member can only receive coverage when the premium has been paid. Capitation payments will not be paid unless verification of premium payment through the roster is received. If payment is not current within that timeframe, the employer group or individual member will not be covered for the next month and will not be able to enroll in an SCI MCO for a period of twelve months for an employer group or six months for an individual member.

[~~D.~~] E. **Responsibility for premium payment:** For members in an employer group, the employer shall be responsible for ensuring payment of the employer and employee share (if any) of premiums. For individuals who are not affiliated with an employer group, the individual or an entity paying on behalf of an individual shall be responsible for payment of both the employer and individual premium amount (if any). If a member who is part of an employer group has met the cost-sharing maximum, as verified by the MCO, HSD shall be responsible for payment of the member's; but not the employer's share of premiums. For individual members not in an employer group who have met the cost-sharing maximum, HSD shall be responsible for the member's share of the premium. The member will continue to be responsible for the employer's share of the premium.

[8.306.11.9 NMAC - N, 7-1-05; A, 3-1-06; A, 4-16-07; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.306.12 NMAC, Sections 8 and 12, which will be effective July 1, 2009.

8.306.12.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.

[8.306.12.8 NMAC - N, 7-1-05; A, 7-1-09]

8.306.12.12 APPEALS: An appeal is a request for review by the MCO of an MCO action.

A. Action is defined as:

(1) the denial or limited authorization of a requested service, including the type or level of service;

(2) the reduction, suspension, or termination of a previously authorized service;

(3) the denial, in whole or in part, of payment for a service;

(4) the failure of the MCO to provide services in a timely manner, as defined by HSD; or

(5) the failure of the MCO to complete the authorization request in a timely manner as defined in 42 CFR Section 438.408.

B. **Notice of MCO action:** The MCO shall mail a notice of action to the member or provider within 10 days of the date of an action for previously authorized services as permitted under 42 CFR 431.213 and 431.214 and within 14 days of the action for newly requested services. Denials of claims which may result in member financial liability require immediate notification. The notice must contain but not be limited to the following:

(1) the action the MCO has taken or intends to take;

(2) the reasons for the action;

(3) the member's or the provider's right, as applicable, to file an appeal of the MCO action through the MCO;

(4) the member's right to request an HSD fair hearing and what the process would be;

(5) the procedures for exercising the rights specified;

(6) the circumstances under which expedited resolution of an appeal is available and how to request it; and

(7) the member's right to have benefits continue pending resolution of an appeal or fair hearing, how to request the continuation of benefits, and the circumstances under which the member may be required to pay the costs of continuing these benefits.

C. Since value added services are not medicaid funded services, there is no appeal or fair hearing rights for SCI members regarding these services. A denial of a value added service will not be considered an action. The MCO shall send the member a notification letter if the value added services in not approved.

[~~C.~~] D. A member may file an appeal of an MCO action within 90 calendar days of receiving the MCO's notice of action. The legal guardian of the member for incapacitated adults, a representative of the member as designated in writing to the MCO, or a provider acting on behalf of the member with the member's written consent, have the right to file an appeal of an action on behalf of the member. The MCO/SE shall consider the member, representative or estate representative of a deceased member as parties to the appeal.

[~~D.~~]E. The MCO has 30 calendar days from the date the oral or written appeal is received by the MCO to resolve the appeal. The MCO shall appoint at least one person to review the appeal who is qualified to make the decision and was not involved in the initial decision [~~and who is not the subordinate of any person involved in the initial decision~~].

[~~E.~~] F. The MCO shall have a process in place [~~that~~] that assures that an oral inquiry from a member seeking to appeal an action is treated as an appeal (to establish the earliest possible filing date for the appeal). An oral appeal must be followed by a written appeal within 10 calendar days that is signed by the member. The MCO will make best efforts to assist members as needed with the written appeal.

[~~F.~~] G. Within five working days of receipt of the appeal, the MCO shall provide the grievant with written notice that the appeal has been received and the expected date of its resolution. The MCO shall confirm in writing receipt of oral appeals, unless the member or the provider requests an expedited resolution.

[~~G.~~] H. The MCO may extend the 30 day timeframe by 14 calendar days if the member requests the extension, or the MCO demonstrates to HSD that there is need for additional information, and the extension is in the member's interest. For any extension not requested by the member, the MCO must give the member written notice of the extension and the reason for the extension within two working days of the decision to extend the timeframe.

[~~H.~~] I. The MCO shall provide the member or the member's representative a reasonable opportunity to present evidence, and allegations of the fact or law, in person as well as in writing.

[~~I.~~] J. The MCO shall provide the member or the representative the opportunity, before and during the appeals process, to examine the member's case file, including medical or clinical records, and any other documents and records considered during the appeals process. The MCO shall include as parties to the appeal the member and his or her representative, or the legal representative of a deceased member's estate.

[~~J.~~] K. For all appeals, the MCO shall provide written notice within the 30-calendar day timeframe of the appeal resolution to the member or the provider, if the provider filed the appeal.

(1) The written notice of the appeal resolution must include, but not be limited to, the following information:

(a) the result(s) of the appeal resolution; and

(b) the date it was completed.

(2) The written notice of the appeal resolution for appeals not resolved wholly in favor of the member must include, but not be limited to, the following information:

(a) the right to request an HSD fair hearing and how to do so;

(b) the right to request receipt of benefits while the hearing is pending, and how to make the request; and

(c) that the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's action.

[~~K.~~] L. The MCO may continue benefits while the appeal or the HSD fair hearing process is pending.

(1) The MCO must continue the member's benefits if all of the following are met:

(a) the member or the provider files a timely appeal of the MCO/SE action or asks for a fair hearing within 13 days from the date on the MCO/SE notice of action;

(b) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(c) the services were ordered by an authorized provider;

(d) the time period covered by the original authorization has not expired; and

(e) the member requests extension of the benefits.

(2) The MCO shall provide benefits until one of the following occurs:

(a) the member withdraws the appeal;

(b) 13 days have passed since the date of the resolution letter, provided the resolution of the appeal was against the member and the member has taken no further action;

(c) HSD issues a hearing decision adverse to the member; and

(d) the time period or service limits of a previously authorized service has expired.

(3) If the final resolution of the appeal is adverse to the member, that is, the MCO's action is upheld, the MCO may recover the cost of the services furnished to the member while the appeal was pending to the extent that services were furnished solely because of the requirements of this section, and in accordance with the policy in 42 CFR Section 431.230(b).

(4) If the MCO or HSD reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

(5) If the MCO or HSD reverses a decision to deny, limit or delay services and the member received the disputed services

while the appeal was pending, the MCO must pay for these services.

(6) If HSD reverses a decision to deny eligibility, the potential member can enroll with the MCO, but there will be no retroactive enrollment or benefit coverage under such circumstances.

[8.306.12.12 NMAC - N, 7-1-05; A, 4-16-07; A, 6-1-08; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.306.13 NMAC, Sections 8 and 10, which will be effective July 1, 2009.

8.306.13.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost-effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.

[8.306.13.8 NMAC - N, 7-1-05; A, 7-1-09]

8.306.13.10 MANAGED CARE ORGANIZATION REQUIREMENTS: The MCO shall have in place internal controls and policies and procedures that are capable of preventing, detecting, investigating and reporting potential fraud and abuse activities concerning both providers [~~and/or~~] or members. The MCO specific internal controls and policies and procedures shall be described in a comprehensive written plan submitted to HSD or its designee for approval. Substantive amendments or modifications to the policies and procedures shall be approved by HSD. The MCO shall maintain procedures for reporting potential and actual fraud and abuse by clients or providers to HSD. The MCO shall:

A. have internal procedures that facilitate preliminary investigating and reporting of potential and actual fraud and abuse to HSD or its designee for further investigation;

B. have specific controls in place for prevention and detection of potential cases of fraud and abuse such as: claims edits, post processing review of claims, provider profiling/exception reporting and credentialing; prior authorizations, utilization/quality management monitoring;

C. have a mechanism to work with HSD or its designee to further develop prevention and detection mechanisms and best practices and to monitor outcomes for SCI;

D. have internal procedures to prevent, detect and investigate program violations to recover funds misspent due to fraudulent or abusive actions;

E. report to HSD the names of all providers identified with aberrant utilization according to provider profiles, regardless of the cause of aberrancy[~~.~~];

F. report to HSD any administrative action taken to limit the ability of an individual or entity to participate in the program;

G. report to HSD any individual or entity that has been excluded from providing items or services to SCI members;

[~~F.~~] H. designate a compliance officer and a compliance committee who are accountable to senior management; [~~and~~]

[~~G.~~] I. provide effective fraud and abuse detection training, administrative remedies for false claims and_statements and whistleblower protection under such laws to the MCO's employees that include:

(1) written policies for all employees, agents or contractors that provide detailed information regarding the New Mexico Medicaid False Claims Act, NMSA 1978, and the federal False Claims Act established under sections 3729 through 3733 of Title 31, United States Code, administrative remedies for false claims and statements established under Chapter 38 of Title 31, United States Code, including but not limited to, preventing and detecting fraud, waste and abuse in federal health care programs (as defined in section 1128B (f) of the Social Security Act);

(2) as part of such written policies, detailed provision regarding the MCO's policies and procedures for detecting and preventing fraud, waste and abuse; and

(3) in any employee handbook, a specific discussion of the laws described in Paragraph (1) above, the rights of employees to be protected as whistleblowers, and the contractor's of subcontractor's policies and procedures for detecting and preventing fraud, waste and abuse;

[~~H.~~] J. implement effective lines of communication between the compliance officer and the MCO's employees;

[~~I.~~] K. require enforcement of standards through well-publicized disciplinary guidelines; and

[~~J.~~] L. have a provision for prompt response to detected offenses and for development of corrective_action initiatives relating to the MCO's contract.

[8.306.13.10 NMAC - N, 7-1-05; A, 6-1-08; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.306.15 NMAC, Sections 8, 9, 11 and 13, which will be effective July 1, 2009.

8.306.15.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost-effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of the communities.

[8.306.15.8 NMAC - N, 7-1-05; A, 7-1-09]

8.306.15.9 SERVICES FOR SCI MEMBERS WITH SPECIAL HEALTH CARE NEEDS (SCI-SHCN):

A. SCI-SHCN require a broad range of primary, specialized medical, behavioral health and related services. SCI-SHCN are individuals who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition, [~~or low to severe functional limitation~~] and who [~~also~~] require health and related services of a type or amount beyond that required by other individuals. SCI-SHCN have ongoing health conditions, high or complex service utilization, and low to severe functional limitations. The primary purpose of the definition is to identify these individuals so that the MCO can facilitate access to appropriate services. The definition also allows for flexible targeting of individuals based on clinical justification and discontinuing targeted efforts when such efforts are no longer needed.

B. **Identification of enrolled SCI-SHCN:** The MCO shall have written policies and procedures in place with HSD approval, which govern how members with multiple and complex physical and behavioral health care needs shall be identified. The MCOs shall have an internal operational process, in accordance with policy and procedure, to target members for the purpose of applying stratification criteria to identify SCI-SHCNs. The MCO shall employ reasonable effort to identify SCI-SHCNs based at least on the following criteria:

(1) individuals eligible for SSI;

(2) individuals identified by service utilization, clinical assessment, or diagnosis; and

(3) [~~referral~~] individuals referred by family or a public or community program.

[8.306.15.9 NMAC - N, 7-1-05; A, 6-1-08; 7-1-09]

8.306.15.11 CHOICE OF SPECIALIST AS PCP: The MCO shall develop and implement policies and procedures governing the process for member selection of a PCP, including the right by an SCI-SHCN to choose a specialist as a PCP, including a psychiatrist in the case of behavioral health. The specialist provider must agree to [~~be the PCP~~] provide all mandated PCP services. See 8.306.6.12 NMAC, *primary care providers*.
[8.306.15.11 NMAC - N, 7-1-05; A, 7-1-09]

8.306.15.13 CARE COORDINATION FOR SCI-SHCN: The MCOs shall develop policies and procedures to provide care coordination for SCI-SHCN. Please refer to 8.306.9 NMAC, *Coordination of Benefits*, for definition.

A. The MCO shall have an internal operational process, in accordance with policy and procedure, to target medicaid members for purposes of applying stratification criteria to identify those who are potential SCI-SHCN. The contractor will provide HSD with the applicable policy and procedure describing the targeting and stratification process.

B. The MCO shall have written policies and procedures to ensure that each member identified as having special health care needs is assessed by an appropriate health care professional regarding the need for care coordination. If the member has both physical and behavioral health special needs, the MCO and SE shall coordinate care in a timely collaborative manner.

C. The MCO shall have written policies and procedures for educating SCI-SHCN [~~needs~~] about available care coordination and when it may be appropriate.
[8.306.15.13 NMAC - N, 7-1-05; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.306.16 NMAC, Sections 8 and 9, which will be effective July 1, 2009.

8.306.16.8 MISSION STATEMENT: The mission of the medical assistance division is to [~~ensure access to quality and cost-effective health care~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of the communities.
[8.306.16.8 NMAC - N, 7-1-05; A, 7-1-09]

8.306.16.9 MEMBER TRANSITION OF CARE: Transition of care refers to the movement of a member from one health care practitioner or setting to another as his/her condition and care requires change. The MCO shall have the resources, [~~and~~] policies and procedures in place to ensure continuity of care without disruption in service to members and [~~to~~] assure the service provider of payment. The MCO shall actively assist with transition of care issues. During the individual member's SCI recertification of eligibility period and re-enrollment, the member may switch enrollment to a different MCO. Employer groups may also switch MCOs during the group re-enrollment process. Certain members may lose their SCI eligibility while enrolled in an MCO. A member changing from one MCO to another SCI MCO shall continue to receive medically necessary services in an uninterrupted manner.

A. **Member transition:** The MCO shall have policies and procedures that address member identification and the clinical transition and transfer of members into or out of the MCO, including the [~~CLTS program~~] CoLTS MCO.

(1) The MCO shall have policies and procedures that cover potentially large or mass transfer of members into or out of the MCO, including the identification of members currently receiving services.

(2) The MCO shall have policies and procedures covering the transition into the MCO of an individual member, which shall include member education about the MCO, about self-care and the optimization of treatment, and the review and update of existing treatment plans.

(3) The MCO shall have policies and procedures that identify members transferring out of the MCO and ensure the provision of member data and clinical information to the future MCO necessary to avoid delays in member treatment.

B. **Special payment requirement:** The MCO shall be responsible for payment of covered medical services, provided to the member for any month the MCO receives a capitation payment, even if the member has lost SCI eligibility.

C. Tracking of members who are nearing the annual claims benefit maximum or annual bed-day maximum:

(1) MCOs will track dollars paid for claims and hospital inpatient days (including home care days) for each SCI member and identify individuals who are at 50 percent of claims benefits paid out in a benefit year and those who have utilized 80[~~%~~] percent of their available hospital inpatient resources.

(2) Identified members who are at the 50 percent level of claims payments or at 80[~~%~~] percent of hospital inpatient days available will have all care coordinated by the MCO to identify methods to manage care so as to best utilize the remaining dollars and days to maximize care and prevent member from reaching benefit claims [~~and/or~~] or hospital day maximum thresholds.

(3) MCO will provide information on these individuals to HSD who will work in conjunction with the MCO to find alternative health care options for these individuals.

D. **Claims processing and payment:** In the event that an MCO's contract with HSD has ended, is not renewed or is terminated, the CONTRACTOR shall remain responsible for processing and paying claims for services delivered through the contract period, but submitted after the MCO's contract has ended.

(1) The MCO shall be required to inform providers in writing, at least 30 days prior to the end of the contract, of the termination of the contract and of the process for providers to submit claims for services provided through the contract end date. The letter shall include the telephone, fax numbers, and the billing address for claims submissions as well as the names of persons to contact with questions.

(2) The MCO shall allow six months to process claims for services provided prior to the contract termination date.

(3) The MCO shall continue to meet timeframes established for processing all claims.
[8.306.16.9 NMAC - N, 7-1-05; A, 6-1-08; A, 7-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.352.2 NMAC, Sections 8 and 16, which will be effective July 1, 2009.

8.352.2.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to [~~maximize the health status of medicaid eligible individuals by furnishing payment for quality health services at levels comparable to private health plans~~] reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their community.
[2-1-95; 8.352.2.8 NMAC - Rn, 8 NMAC 4.MAD.002, 7-1-01; A, 7-1-09]

8.352.2.16 CONTINUATION OF BENEFITS PURSUANT TO TIMELY APPEAL OF HEARING DECISION:

A. Continuation of benefits may be provided to recipients who request a hearing within 13 days of the notice. The notice will include information on the rights to continued benefits and on

the recipient's responsibility for repayment if the hearing decision is not in the recipient's favor.

B. Repayment responsibility:

(1) When a recipient appeals an issue of medicaid eligibility as described in 8.100.970 NMAC, *Fair Hearings*, has requested continued benefits pursuant to timely appeal, and the hearing decision upholds HSD's or the involved contractor's proposed action, the overpayment amounts will be calculated as follows:

(a) Fee-for-service month: The medicaid paid amount (paid claims amount) is owed to HSD.

(b) [~~SALUD!~~] Salud! enrolled month: HSD is owed the capitation amount plus the medicaid paid claim amount for any carved-out services.

(2) When a recipient appeals a termination, modification, reduction, or suspension of a service as described in this part, and has requested benefit continuation pursuant to timely appeal, and the hearing decision upholds HSD or the contractor's proposed action, the amount owed by the recipient will be calculated as follows: HSD will be owed the medicaid reimbursable amount for the period of time that the service was continued in the interim period pending the hearing decision, for fee-for-service and [~~SALUD!~~] Salud! enrolled recipients when the service at issue is covered under medicaid fee-for-service. The MCO will be owed and is responsible to collect the medicaid reimbursable amount for the period of time that the service was continued in the interim period pending the hearing decision when the service was provided by the MCO. Collections by the MCO must be used for medicaid Salud! program purposes.

C. For SCI-enrolled clients only: Continuation of benefits may be provided to SCI recipients who are enrolled with an SCI MCO and request a hearing within 13 days of the notice. The notice will include information about the rights to continued benefits and about the recipient's responsibility for repayment if the hearing decision is not in the recipient's favor. If the SCI enrolled client has met his claim benefit maximums (dollars or bed days or prescriptions for the month) or has not paid premiums or paid premiums late, he will not have continuation of benefits when requesting a hearing within 13 days of the notice.

[1-1-00; 8.352.2.16 NMAC - Rn, 8 NMAC 4.MAD.977 & A, 7-1-01; A, 4-16-07; A, 7-1-09]

NEW MEXICO PUBLIC EDUCATION DEPARTMENT

This is an amendment to 6.80.4 NMAC, Sections 7, 8, 11, 12, 13, and 19 through 21, effective June 30, 2009.

6.80.4.7 DEFINITIONS:

A. "Applicant" means one or more teachers, parents or community members or a public post-secondary educational institution or nonprofit organization who submits an initial or renewal application to a chartering authority.

B. "Authorizer" means either a local school board or the commission that permits the operation of a charter school.

C. "Charter school" means a conversion school or start-up school authorized by a chartering authority to operate as a public school.

D. "Chartering authority" means either a local school board or the commission that permits the operation of a charter school.

E. "Chief executive officer" means the person with duties similar to that of a superintendent as set forth in 22-5-14 NMSA 1978.

F. "Commission" means the public education commission.

G. "Conversion school" means an existing public school within a school district that was authorized by a local school board or the commission to become a charter school.

H. "Department" means the public education department.

I. "Division" means the charter schools division of the department which maintains offices in both Santa Fe and Albuquerque.

J. "Governing body" means the governing body of a charter school as set forth in the school's charter.

K. "Head administrator" means the duly licensed school administrator who is the chief executive officer of the charter school.

L. "Locally chartered charter school" means a charter school authorized by a local school board.

M. "MEM" means membership, which is the total enrollment of qualified students on the current roll of a class or school on a specified day.

N. "New Mexico coalition for charter schools" means the non-profit membership organization representing charter schools in New Mexico.

O. "New Mexico school boards association" means the organization consisting of the local public school boards and the governing bodies of charter schools in New Mexico.

[~~N.~~] P. "Organizer" means one or more persons or entities who seek to arrange, form or otherwise put together a charter school.

[~~O.~~] Q. "Prospective applicant" means one or more teachers, parents or community members or a public post-secondary educational institution or nonprofit organization who submits a notice of intent to a chartering authority.

[~~P.~~] R. "Secretary" means the New Mexico secretary of public education.

[~~Q.~~] S. "Start-up charter school" means a public school developed by one or more parents, teachers or community members who applied to and were authorized by a chartering authority to become a charter school.

[~~R.~~] T. "Application for start-up charter school" means an application requesting the establishment of either a locally-chartered or state-chartered school.

[~~S.~~] U. "Special education plan" means a comprehensive written design, scheme or method that includes specific details on how the charter school shall:

(1) utilize state and federal funds to provide children with disabilities a free and appropriate public education, in accordance with applicable law;

(2) provide educational services, related services and supplementary aids and services to children with disabilities in accordance with each child's individualized education program; and

(3) address a continuum of alternative educational placements to meet the needs of students with disabilities, in accordance with applicable law.

[~~T.~~] V. "State-chartered charter school" means a charter school authorized by the commission.

[6.80.4.7 NMAC - Rp, 6.80.4.7 NMAC, 6/29/07; A, 6/30/08; A, 6/30/09]

6.80.4.8 NOTICE OF INTENT TO ESTABLISH A CHARTER SCHOOL:

A. [~~At least one hundred eighty (180) calendar days prior to initial application,~~] The organizers of a proposed charter school shall provide a signed written notification to the commission and the school district in which the charter school is to be located of the organizers' intent to establish a charter school. The date for submitting a notice shall be no later than [~~January 1~~] the second Tuesday of January of the year in which the prospective applicant plans to submit an application.

B. Written notification to the commission shall be made to the division at its Albuquerque office; written notification to a local school board shall be made to the superintendent of that district

who shall provide copies of the notification to the local school board during a duly noticed board meeting.

C. If [~~the one hundred eightieth day falls on a Saturday, Sunday, or legal holiday,~~] the second Tuesday of January falls on a legal holiday, the notification shall be timely if [~~faxed, hand delivered or otherwise received~~] personally delivered on the first day following the [~~Saturday, Sunday or~~] legal holiday that the division or office of the pertinent superintendent is open for business. Notice will also be considered timely if it is postmarked four (4) calendar days prior to [~~January 1,~~] the second Tuesday of January, regardless of the date on which it is received. Failure to provide timely notification [~~shall~~] may result in an application being rejected unless the organizers can demonstrate good cause why timely notification was not given.

[6.80.4.8 NMAC - N, 6/29/07; A, 6/30/08; A, 6/30/09]

6.80.4.11 REQUIREMENTS DURING THE PLANNING YEAR:

A. For charter schools approved prior to July 1, 2010, prior to the end of its planning year, a newly authorized charter school shall demonstrate to the authorizer that its facilities meet the educational occupancy standards required by applicable New Mexico construction codes. For charters approved on or after July 1, [~~2010~~] 2015, prior to the end of its planning year, the charter school shall demonstrate to its authorizer that its facilities meet the relevant requirements for schools as set forth in Section 22-8B-4.2C, NMSA 1978.

B. A charter school shall simultaneously notify the public school capital outlay council and its authorizer in writing of its readiness to demonstrate that its facilities meet the referenced educational occupancy standards.

C. The public school capital outlay council shall determine whether a charter school's facilities meet established educational occupancy standards, and if not, whether specific requirements are inappropriate or unreasonable for a charter school. If the public school capital outlay council determines that specific requirements of the referenced educational occupancy standards are inappropriate or unreasonable for a charter school, it may grant a variance. The public school capital outlay council shall provide written notification of its decision and the reasons thereto simultaneously to the charter school and its authorizer.

D. Prior to the end of its planning year, a state chartered charter school shall demonstrate that it has qualified as a board of finance and that it has satisfied any conditions imposed by the commission before commencing full operation for the remainder of its charter term.

E. Prior to the end of its planning year, the state-chartered charter schools shall apply to the commission for authorization to commence full operations. If the commission refuses to issue the authorization to commence full operation, it shall provide its reasons in writing which shall be limited to the reasons set forth in Subsection D of 6.80.4.11 NMAC.

[6.80.4.11 NMAC - N, 6/29/07; A, 6/30/08; A, 6/30/09]

6.80.4.12 INITIAL REQUIREMENTS AND REVIEW PROCESS FOR START-UP SCHOOLS:

A. Local school boards may approve the establishment of charter schools to be located in their respective districts. The commission may approve the establishment of a charter school to be located anywhere in the state.

B. An applicant shall apply to only one chartering authority at a time. An applicant whose application has been denied by a chartering authority or approved with amendments unacceptable to the applicant may file the same application the following fiscal year with a different chartering authority.

C. Applications for start-up schools shall be submitted [~~by~~] between June 1 and July 1 to be eligible for consideration for the following fiscal year. [~~The July 1 submission deadline may be waived upon agreement of the applicant and the chartering authority.~~] If July 1 falls on a Saturday or a Sunday, the deadline for filing applications shall be extended to the close of business of the very next Monday, even in the case of a school district closed for summer break. Applications will also be considered timely if they are postmarked four (4) calendar days prior to July 1, regardless of the date on which they are received. Failure to submit a timely application shall result in an application being rejected by the authorizer, unless the parties agree to waive the filing deadline in accordance with Section 22-8B-6 NMSA 1978. Any such waiver shall be in writing and signed by [~~a person~~] persons authorized to take such action by the applicant and the chartering authority.

D. Enrollment in a start-up charter school shall be guided by the following.

(1) A charter applicant must enroll students on a first-come, first-served basis or through a lottery selection process if the total number of applicants exceeds the number of spaces available.

(2) A charter applicant shall advertise its enrollment process using newspapers, bulletin boards and other methods designed to disseminate its availability to seek student enrollment and to ensure that there is equal opportunity for all parents and students to learn about the school and apply.

(3) A charter school shall not charge tuition or have admission requirements, except as otherwise provided in the Public School Code, Sections 22-1-1 et seq., NMSA 1978.

(4) In subsequent years of its operation, a charter school will give enrollment preference to previously properly admitted students who remain in attendance and siblings of students already admitted to or attending the school.

E. Any revision or amendment to the terms of the charter contract may be made only with the written approval of the authorizer.

F. A charter school shall be a nonsectarian, nonreligious, and non-home-based public school that operates within the geographic boundaries of a public school district.

G. A charter school shall comply with the Age Discrimination Act of 1975, Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and Part B of the Individuals with Disabilities Education Act.

H. A charter school shall comply with the same federal and state audit requirements as do other public schools in the state.

I. A charter school shall meet all applicable federal, state, and local health and safety requirements.

J. A charter school shall operate in accordance with and under authority of state law.

K. A charter school shall provide equitable access to, and participation in, its federally assisted program for students, teachers, and other program beneficiaries with special needs.

L. A charter school shall have an admissions process that does not discriminate against anyone on the basis of race, gender, national origin, color, disability, or age.

M. A charter school's head administrator or governing body shall not employ or approve the employment in any capacity of a person who is the spouse, father, father-in-law, mother, mother-in-law, son, son-in-in-law, daughter, [~~or~~] daughter-in-law, brother, brother-in-law, sister or sister-in-law of a member of the governing body or the head administrator [~~or any governing body members~~]. The governing body may waive the nepotism rule for family members of a head administrator.

N. Applications to the commission for establishment of a state chartered charter school shall be made to the division at its Albuquerque office. Applications to a local school board for

establishment of a locally chartered charter school shall be made to the superintendent of that district.

O. An application for a start-up school may be made by one or more teachers, parents, community members, by a public post-secondary educational institution or a nonprofit organization.

P. The chartering authority shall be responsible for reviewing all applications for charter schools. Prior to the submission of the applications, the division shall provide at least three (3) technical assistance workshops for prospective applicants on preparing a start-up application. The chartering authority shall not charge application fees.

Q. A review coordinator shall be used by the chartering authority to assist prospective applicants in the preparation of proposed charters. The assistant secretary for the division shall designate a review coordinator in the division for the commission. The superintendent shall appoint a review coordinator for the local school board, unless the superintendent of a school district performs this duty. Prior to the deadline for submission of applications established by the chartering authority, the review coordinator or superintendent and any prospective applicants shall confer in an attempt to identify:

(1) any concerns regarding noncompliance with requirements of the Charter Schools Act (Sections 22-8B-1 et seq., NMSA 1978), this rule or other applicable state or federal laws or regulations which would arise from the establishment or operation of the proposed charter school;

(2) any licensure, curriculum, or other educational concerns which would arise from the establishment or operation of the proposed charter school;

(3) any interests of the students, the school district or the community which would be adversely affected by the establishment or operation of the proposed charter school and describe the apparent adverse effects.

R. Prospective applicants are to direct any request for technical assistance and information through the authorizer's designated review coordinator. The review coordinator or superintendent shall ensure that the appropriate staff members respond to requests from prospective applicants for information on school operations, policies or practices which prospective applicants regard as necessary to enable them to present an approvable application. Prospective applicants may request information using the Inspection of Public Records Act (Chapter 14, Article 2 NMSA 1978). A review coordinator may require that requests for information not made pursuant to the Inspection of Public Records Act be in a format or directed to a specific person or office in the school district or department. Prospective applicants should not contact school district or department employees directly to obtain information.

S. Prior to the public meeting at which the decision is made, the chartering authority shall hold at least one (1) public [~~meeting~~] hearing to obtain information and community input to assist it in its decision whether to grant a charter school application. At any such[~~meeting~~] hearing, which shall be duly noticed and held pursuant to the Open Meetings Act (Chapter 10, Article 15 NMSA 1978) and the requirements contained in the Laws 2009 Chapter 12, members of the chartering authority may ask questions of the charter applicant and that applicant shall have an opportunity, subject to reasonable time limitations, to respond to any questions or concerns raised by any members of the chartering authority, and present to the chartering authority information that clarifies and verifies the information in the application that the applicant believes will assist the chartering authority in making its decision. Community input may include written or oral comments in favor of or in opposition to the application by the applicant, members of the local community and other interested individuals. Community input shall be provided within a time limit established by the chartering authority.

T. A charter applicant shall respond to requests for information that the chartering authority regards as necessary to verify and clarify issues identified in the charter application; each shall communicate in good faith in an attempt to verify and clarify issues identified in the charter application.

U. No earlier than three (3) days after the public [~~meeting~~] hearing to obtain information and community input, the chartering authority shall rule on the application in a public meeting. The public meeting at which the decision is made shall be held [~~within sixty (60) days after receipt of the application unless the applicant and chartering authority agree in writing to extend this deadline. The public meeting in which the chartering authority rules on the application shall be held on or before the extended deadline. If not ruled upon within sixty (60) days, the charter application will be automatically reviewed by the secretary pursuant to the applicable provisions of Section 22-8B-7 NMSA 1978, 6.80.4.11 NMAC and 6.80.4.12 NMAC above. The charter applicant and the chartering authority may, however, jointly waive the deadlines set forth in this subsection, provided they do so in a signed written statement.~~] by September 1. The charter applicant and the chartering authority may, however, jointly waive the September 1 deadline provided they do so in a signed written statement. If not ruled upon by September 1, or the stipulated deadline, the charter application will be automatically reviewed by the secretary pursuant to the applicable provisions of Section 22-8B-7 NMSA 1978 and 6.80.4.14 NMAC.

V. A chartering authority may approve, approve with conditions or deny an application. A chartering authority may deny an application where:

(1) the application is incomplete or inadequate;

(2) the application does not propose to offer an educational program consistent with the requirements and purposes of the Charter Schools Act (Chapter 22, Article 8B NMSA 1978);

(3) the proposed head administrator or other administrative or fiscal persons were involved with another charter school whose charter was denied or revoked for fiscal mismanagement or the proposed head administrator or other administrative or fiscal member was discharged from a public school for fiscal mismanagement;

(4) the public school capital outlay council has determined that the facilities do not meet the standards required in Section 22-8B-4.2 NMSA 1978;

(5) for a proposed state-chartered charter school, it does not request the governing body to be designated as a board of finance, or the governing body does not qualify as a board of finance; or

(6) the application is otherwise contrary to the best interests of the charter school's projected students, the local community or the school district in whose geographic boundaries the applicant seeks to operate.

W. If the chartering authority denies a charter school application or approves the application with conditions, it shall state its reasons for the denial or imposition of conditions in writing within fourteen (14) days of the meeting. The written decision must be based upon the vote that was taken at the public meeting and reflect the stated reasons for the vote of the chartering authority to deny a charter school application or approve the application with conditions. If the chartering authority grants a charter, it shall deliver the approved charter to the applicant. The time within which to file notice of appeal shall commence upon receipt of the written denial. The chartering authority shall maintain a copy of the charter for its files.

X. If the approved charter contains a waiver request for release from department rules or the Public School Code the applicant must follow the procedures on requesting waivers from the department. The department shall notify the authorizer

and the charter school whether the request is granted or denied and, if denied, the reasons thereto.

Y. If the authorizer denies a charter school application or imposes conditions for approval that are unacceptable to the charter applicant, the applicant may appeal the decision to the secretary pursuant to Section 22-8B-7 NMSA 1978 and section 6.80.4.14 NMAC.

[6.80.4.12 NMAC - Rp, 6.80.4.9 NMAC, 6/29/07; A, 6/30/08; A, 6/30/09]

6.80.4.13 CHARTER SCHOOL RENEWAL PROCESS AND RENEWAL APPLICATIONS:

A. The governing body of a charter school seeking to renew its charter shall file its renewal application with a chartering authority no earlier than two hundred seventy (270) days prior to the date the charter expires. Commencing with any charters that are due to expire at any time after January 1, 2008, all applications for renewal shall be submitted no later than October 1 of the fiscal year prior to the expiration of the school's charter. The chartering authority shall rule in a public meeting on the renewal application no later than January 1 of the fiscal year in which the charter expires.

B. The governing body may submit its charter renewal application to either the commission or to the local school board of the district in which the charter school is located, but may not submit the renewal application to both authorizers simultaneously.

C. The application shall contain:

(1) a report on the progress of the charter school in achieving the goals, objectives, student performance standards, state minimum educational standards and other terms of the initial approved charter application, including the accountability requirements set forth in the Assessment and Accountability Act (Section 22-2C-1 et seq. NMSA, 1978);

(2) a financial statement that discloses the costs of administration, instruction and other spending categories for the charter school that is understandable to the general public, that will allow comparison of costs to other schools or comparable organizations and that is in a format required by the department;

(3) any changes to the original charter the governing board is requesting and any amendment to the initial charter, which were previously approved;

(4) a certified petition in support of the charter school renewing its charter status signed by not less than sixty-five (65) percent of the employees in the charter school;

(5) a certified petition in support of the charter school renewing its charter status signed by at least seventy-five (75) percent of the households whose children are enrolled in the charter school as identified in the school's 120-day report of the fiscal year prior to the expiration of the charter;

(6) a description of the charter school facilities and assurances that the facilities are in compliance with the requirements of Section 22-8B-4.2 NMSA 1978; and

(7) a statement of the term of the renewal requested, if less than five (5) years; if a charter school renewal application does not include a statement of the term of the renewal, it will be assumed that renewal is sought for a term of five (5) years.

[~~D. The chartering authority shall rule on the renewal application in a public hearing no later than one hundred eighty (180) days prior to the expiration of the charter unless the applicant and the chartering authority agree in writing to extend this deadline. A subsequent public meeting shall be held on or before the extended deadline. If not ruled upon within sixty (60) days, the charter renewal application will be automatically reviewed by the secretary pursuant to the applicable provisions of Sections 22-8B-7 NMSA 1978 and 6.80.4.14 NMAC.~~]

[~~E.~~] D. A chartering authority may refuse to renew a charter if it determines that:

(1) the charter school committed a material violation of any of the conditions, standards or procedures set forth in the charter;

(2) the charter school failed to meet or make substantial progress toward achievement of the department's minimum educational standards or student performance standards identified in the charter application;

(3) the charter school failed to meet generally accepted standards of fiscal management;

(4) the charter school violated any provision of law from which the charter school was not specifically exempted;

(5) the public school capital outlay council has determined that the facilities do not meet the standards required in Section 22-8B-4.2 NMSA 1978.

[~~F.~~] E. If the chartering authority refuses to approve a charter school renewal application or approves the renewal application with conditions, it shall state its reasons for the non-renewal or imposition of conditions in writing within fourteen (14) days of the meeting; provided that if the chartering authority grants renewal of a charter, it shall deliver the approved charter to the applicant and a copy to the chartering authority. The chartering authority shall keep a copy of the charter for its files.

[~~G.~~] F. If the approved charter contains a waiver request for release from department rules or the Public School Code, the department shall notify the authorizer and the charter school whether the request is granted or denied and, if denied, the reasons thereto.

[~~H.~~] G. If the authorizer refuses to approve a charter school renewal application or imposes conditions for renewal that are unacceptable to the charter applicant, the applicant may appeal the decision to the secretary pursuant to Sections 22-8B-7 NMSA 1978 and 6.80.4.14 NMAC.

[~~I.~~] H. The provisions of this section shall apply to conversion schools.

[6.80.4.13 NMAC - Rp, 6.80.4.8 NMAC, 6/29/07; A, 6/30/08; A, 6/30/09]

6.80.4.19 LOTTERY WHEN CHARTER SCHOOL CAP IS EXCEEDED:

A. For purposes of compliance with Section 22-8B-11, NMSA 1978, the first five year period shall be deemed to have ended in 2003 and the successive five-year periods begin in 2003.

B. If by October 1st the chartering authorities have authorized more charter schools than permitted by Section 22-8B-11, NMSA 1978, the department shall notify all chartering authorities with newly authorized charter schools that those charter schools may not be established for operations until a lottery is held.

C. Within 45 days after determining that the cap for charter schools has been exceeded, the department shall conduct a lottery at a publicly noticed meeting to determine the available slots for charter schools. The department shall randomly draw the names of charter schools from the available pool of all charter schools that were authorized by October 1st. The schools whose names were drawn shall be given the available charter school slots until the maximum numbers of slots have been selected. The charter schools that are selected shall be approved for operation in the first fiscal year after the lottery. The charter schools whose names were not drawn shall be approved for operation in the second fiscal year after the lottery.

D. A charter school that was approved for operation in the second fiscal year after participation in a lottery shall not be subject to a second lottery in the event that in the second fiscal year more charter schools are authorized than permitted by Section 22-8B-11, NMSA 1978.

E. Any charter school authorized after October 1st in a year in which the department conducts a lottery pursuant to this rule, shall be approved for operation no earlier than the second fiscal

year after the school was authorized.
[6.80.4.19 NMAC - Rn, 6.80.4.17 NMAC, 6/30/08; 6.80.4.19 NMAC - N, 6/30/09]

6.80.4.20 GOVERNING BODY TRAINING:

A. All governing body members of charter schools shall attend five hours of training at least annually on topics that include department rules, policies and procedures, statutory powers and duties of governing boards, legal concepts pertaining to public schools, finance and budget and other relevant matters.

B. Governing body members who have been in office for one or more years shall attend five hours of annual training approved by the department that is sponsored by the New Mexico school boards association (NMSBA) or the New Mexico coalition for charter schools (NMCCS).

C. Newly selected governing body members who have been in office for less than a year, shall receive three of the required five hours from attending a training course developed by the department and sponsored by the NMSBA or the NMCCS. The additional two hours of annual training for new governing body members shall consist of sessions approved by the department that are sponsored by the NMSBA or by the NMCCS.

D. In order to be credited with attendance at training courses, each attendee shall complete written attendance forms provided by the department and kept on file with the charter schools. Prior to September 1 of each year, the NMSBA or the NMCCS shall provide each head administrator of a charter school with a list of training hours earned annually by each governing body member. The accountability report of the school district or charter school shall include the names of those governing body members who failed to attend annual mandatory training.

E. The governing body of a charter school shall develop a planned program of training consistent with this section that ensures that each member of the governing body participates and complies.
[6.80.4.20 NMAC - N, 6/30/09]

[~~6.80.4.19~~] 6.80.4.21 SEVERABILITY: Any part of this rule found by adjudication before a competent tribunal to be contrary to law shall be stricken without affect to the remainder.
[6.80.4.21 NMAC - Rn, 6.80.4.19 NMAC, 6/30/09]

NEW MEXICO RACING COMMISSION

Explantory Paragraph: This is an amendment to Subparagraph (b) of Paragraph (7) of Subsection B of 15.2.1.9 NMAC. This amendment is to eliminate the use of a licensee's social security number and date of birth when a ruling is issued by the Board of Stewards, effective 06/30/09.

15.2.1.9 DUE PROCESS AND DISCIPLINARY ACTION:

. . .

B. PROCEEDINGS BEFORE THE STEWARDS:

(1) Rights of the licensee. A person who is the subject of the disciplinary hearing conducted by the stewards is entitled to: proper notice of all charges; confront the evidence presented including: the right to counsel at the person's expense; the right to examine all evidence to be presented against him/her; the right to present a defense; the right to call witnesses; the right to cross examine witnesses; and waive any of the above rights.

(2) Complaints.

(a) On their own motion or on receipt of a complaint from an official or other person regarding the actions of a licensee, the stewards may conduct an inquiry and disciplinary hearing regarding the licensee's actions.

(b) A complaint made by someone other than the stewards must be in writing and filed with the stewards not later than 72 hours after the action that is the subject of the complaint.

(c) In case of a notice from the state of New Mexico human services department that a licensee is in non-compliance with the Parental Responsibility Act, the licensee shall be notified by the board of stewards. Thereafter the licensee shall have thirty (30) days to provide documentation of compliance to the board of stewards and failure to do so will result in the suspension of the licensee's license.

(3) Summary suspension.

(a) If the stewards determine that a licensee's actions constitute an immediate danger to the public health, safety, or welfare, the stewards may summarily suspend the license pending a hearing.

(b) A licensee whose license has been summarily suspended is entitled to a hearing on the summary suspension not later than the third day after the license was summarily suspended. The licensee may waive his or her right to a hearing on the summary suspension within the three-day limit.

(c) The stewards shall conduct a hearing on the summary suspension in the same manner as other disciplinary hearings. At a hearing on a summary suspension, the sole issue is whether the licensee's license should remain suspended pending a final disciplinary hearing and ruling.

(d) If a positive test arises in a trial race, the horse is eligible for entry during the period the split is tested and reported to the commission. If the report confirms a positive test, the horse is disqualified from both the trial and the race for which the trial was conducted.

(4) Notice.

(a) Except as provided by these rules regarding summary suspension, jockey riding infractions and trial races, the stewards shall provide written notice, at least 10 days before the hearing, to a person who is the subject of a disciplinary hearing. The person may waive his or her right to 10 days notice by executing a written waiver.

(b) Notice given under this section must include: a statement of the time, place and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing is to be held; a reference to the particular sections of the statutes or rules involved; a short, plain description of the alleged conduct that has given rise to the disciplinary hearing; the possible penalties that may be imposed.

(c) If possible, the stewards or their designee shall hand deliver the written notice of the disciplinary hearing to the person who is the subject of the hearing. If hand delivery is not possible, the stewards shall forthwith mail the notice to the person's last known address, as found in the commission's licensing files, by regular mail and by certified mail, return receipt requested. If the disciplinary hearing involves an alleged medication violation that could result in the disqualification of a horse, the stewards shall provide notice of the hearing to the owner of the horse in the manner provided by this subsection.

(d) Nonappearance of a summoned party after adequate notice shall be construed as a waiver of the right to a hearing before the stewards. The stewards may suspend the license of a person who fails to appear at a disciplinary hearing after written notice of the hearing has been sent, in compliance with this subsection.

(5) Continuances.

(a) Upon receipt of a notice, a person may request a continuance of the hearing.

(b) The stewards may grant a continuance of any hearing for good cause shown.

(c) The stewards may at any time order a continuance on their own motion.

(6) Evidence.

(a) Each witness at a disciplinary hearing conducted by the stewards

must be sworn by the presiding steward.

(b) The stewards shall allow a full presentation of evidence and are not bound by the technical rules of evidence. The stewards may admit hearsay evidence if the stewards determine the evidence is of a type that is commonly relied on by reasonably prudent people. The rules of privilege recognized by state law apply in hearings before the stewards. Hearsay evidence alone is insufficient basis for a ruling.

(c) The burden of proof is on the person bringing the complaint to show, by a preponderance of the evidence, that the licensee has violated or is responsible for a violation of the act or a commission rule.

(d) The stewards shall make a tape recording of a disciplinary hearing and make a copy of the recording available on request, at the expense of the requesting person.

(7) Ruling.

(a) The issues at a disciplinary hearing shall be decided by a majority vote of the stewards. If the vote is not unanimous, the dissenting steward shall include with the record of the hearing a written statement of the reasons for the dissent.

(b) A ruling by the stewards must be on a form prescribed by the commission and include: the full name, [~~social security number,~~] date of birth, [~~last record address,~~] license type and license number of the person who is the subject of the hearing; a statement of the charges against the person, including a reference to the specific section of the Racing Act or rules of the commission that the licensee is found to have violated; the date of the hearing and the date the ruling was issued; the penalty imposed; any changes in the order of finish or purse distribution; other information required by the commission.

(c) A ruling must be signed by a majority of the stewards.

(d) If possible, the stewards or their designee shall hand deliver a copy of the ruling to the person who is the subject of the ruling. If hand delivery is not possible, the stewards shall mail the ruling to the person's last known address, as found in the commission's licensing files, by regular mail and by certified mail, return receipt requested. If the ruling includes the disqualification of a horse, the stewards shall provide a copy of the ruling to the owner of the horse, the horsemen's bookkeeper, and the appropriate past performance service.

(e) At the time the stewards inform a person who is the subject of the proceeding of the ruling, the stewards shall inform the person of the person's right to appeal the ruling to the commission and apply for a stay.

(f) All fines imposed by the stewards shall be paid to the commission within 30 days after the ruling is issued, unless otherwise ordered.

(8) Effect of rulings.

(a) Rulings against a licensee apply to another person if continued participation in an activity by the other person would circumvent the intent of a ruling by permitting the person to serve, in essence, as a substitute for the ineligible licensee.

(b) The transfer of a horse to avoid application of a commission rule or ruling is prohibited.

(c) The stewards shall honor the rulings issued by other pari-mutuel racing commissions.

(9) Appeals.

(a) A person who has been aggrieved by a ruling of the stewards may appeal to the commission. A person who fails to file an appeal by the deadline and in the form required by this section waives the right to appeal the ruling.

(b) An appeal under this section must be filed not later than 20 days from the date of the ruling. The appeal must be filed at the main commission offices or with the stewards who issued the ruling.

(i) A ruling appeal excluding riding infractions, must be accompanied by a fee in the amount of $100. The fee must be in the form of a cashier's check, money order or personal check. The commission has the discretion to refund all or part of the fee.

(ii) A ruling appeal regarding a riding infraction must be accompanied by a fee in the amount of $300. The fee must be in the form of a cashier's check, money order or personal check. The commission has the discretion to refund all or part of the fee.

(c) An appeal must be in writing on a form prescribed by the commission. The appeal must include the name, address, telephone number and signature of the person making the appeal; a statement of the basis for the appeal.

(d) On notification by the commission that an appeal has been filed, the stewards shall forward to the commission the record of the proceeding on which the appeal is based, and a statement of the reasons for their rulings.

(e) If a person against whom a fine has been assessed files an appeal of the ruling that assesses the fine, the person shall pay the fine in accordance with these rules. If the appeal is disposed of in favor of the appellant, the commission shall refund the amount of the fine.

(10) Stay.

(a) A person who has been disciplined by a ruling of the stewards may apply to the agency director for a stay of the ruling within 20 days from the date of the ruling.

(b) An application for a stay must be filed with the agency director not later than the deadline for filing an appeal.

(c) An application for a stay must be in writing and include the name, address and telephone number and signature of the person requesting the stay; a statement of the justification for the stay.

(d) On a finding of good cause, the agency director may grant the stay. The agency director shall notify the person in writing of the agency director's decision on the stay application. On a finding of changed circumstances, the agency director may rescind a stay granted under this subsection.

(e) The fact that a stay is granted is not a presumption that the ruling by the stewards is invalid.

. . .

[15.2.1.9 NMAC - Rp, 15 NMAC 2.1.9, 03/15/2001; A, 03/31/2003; A, 05/30/2003; A, 06/15/2004; A, 06/30/09]

NEW MEXICO RACING COMMISSION

This is an amendment to Subsection E of 15.2.3.8 NMAC, effective 06/30/09.

15.2.3.8 FLAT RACING OFFICIALS GENERAL PROVISIONS:

A. Racing Officials. Officials at a race meeting include the following: assistant racing secretary; chief of security; director of racing, or similar position; clerk of scales; clocker; general manager; handicapper; horse identifier; horsemen's bookkeeper; jockey room custodian; official veterinarian; paddock judge; pari mutuel manager; patrol judge, absent video replay equipment; placing judge, if duty not performed by stewards; racing secretary; racing veterinarian; stable superintendent; starter; stewards; timer; track superintendent; any other person designated by the commission.

(1) Eligibility. To qualify as a racing official, the applicant shall: be of good character and reputation; demonstrate experience in flat racing; be familiar with the duties of the position and with the commission's rules of flat racing and show an ability to fulfill the requirements of the position.

(2) Approval and licensing. The commission, in its sole discretion, may determine the eligibility of a racing official and, in its sole discretion, may approve or disapprove any such official for licensing. An association shall submit to the commission its request for approval of racing officials sixty (60) days prior to the first day of the race meet.

(3) Prohibited practices. While serving in an official capacity, racing officials and their assistants shall not: par-

ticipate in the sale or purchase, or ownership of any horse racing at the meeting; sell or solicit horse insurance on any horse racing at the meeting; be licensed in any other capacity without permission of the commission, or in case of an emergency, the permission of the stewards; wager on the outcome of any race under the jurisdiction of the commission; consume or be under the influence of alcohol or any prohibited substances while performing official duties.

(4) Report of violations. Racing officials and their assistants shall report immediately to the stewards every observed violation of these rules and of the laws of this state governing racing.

(5) Complaints against officials. Complaints against any steward shall be made in writing to the commission and signed by the complainant.

(a) Any complaint against a racing official other than a steward shall be made to the stewards in writing and signed by the complainant. All such complaints shall be reported to the commission by the stewards, together with a report of the action taken or the recommendation of the stewards.

(b) A racing official may be held responsible by the stewards or the commission for their actions, and the actions of their assistants and/or employees.

(6) Appointment.

(a) A person shall not be appointed to more than one racing official position at a meeting unless specifically approved by the commission.

(b) The commission shall appoint or approve the stewards at each race meeting

(7) Appointment of substitute officials. Where an emergency vacancy exists among racing officials (except for stewards), the stewards or the association, with the stewards' approval, shall fill the vacancy immediately. Such appointment shall be reported to the commission and shall be effective until the vacancy is filled in accordance with these rules.

(8) Appointment of substitute steward. Should any steward be absent at race time, and no approved alternate steward be available, the remaining stewards shall appoint a substitute for the absent steward. If a substitute steward is appointed, the commission and the association shall be notified by the stewards. The following are prohibited from serving as a substitute steward: director, deputy director, or racing commissioner.

B. Stewards.

(1) General authority. The stewards for each meeting shall be responsible to the commission for the conduct of the race meeting in accordance with the laws of this state and these rules.

(a) The stewards shall enforce these rules and the racing laws of this state.

(b) The stewards' authority includes supervision of all racing officials, track management, licensed personnel, other persons responsible for the conduct of racing, and patrons, as necessary to insure compliance with the act and these rules.

(c) The stewards shall have authority to resolve conflicts or disputes related to racing and to discipline violators in accordance with the provisions of these rules.

(d) The stewards have the authority to interpret the rules and to decide all questions of racing not specifically covered by the rules. Whenever the stewards find any person culpable for any act or omission in violation of these regulations or any violation of the Horse Racing Act, the person shall be subject to disciplinary action, which could include a fine, suspension, or revocation/denial of license or any combination of these penalties.

(2) Period of authority. The stewards' period of authority shall commence up to ten days prior to the beginning of each meeting and shall terminate with the completion of their business pertaining to the meeting. Following the completion of the stewards' business, the agency director shall carry out the duties of the stewards as described in this chapter.

(3) Disciplinary action. The stewards shall take notice of alleged misconduct or rule violations and initiate investigations into the matters.

(a) The stewards shall have authority to charge any licensee for a violation of these rules, to conduct hearings and to impose disciplinary action in accordance with these rules.

(b) The stewards may compel the attendance of witnesses and the submission of documents or potential evidence related to any investigation or hearing.

(c) The stewards may at any time inspect license documents, registration papers, and other documents related to racing.

(d) The stewards have the power to administer oaths and examine witnesses.

(e) The stewards shall consult with the official veterinarian to determine the nature and seriousness of a laboratory finding or an alleged medication violation.

(f) The stewards may impose any of the following penalties on a licensee for a violation of the act or these rules: issue a reprimand; assess a fine; require forfeiture or redistribution of purse or award, when specified by applicable rules and/or at their discretion; place a licensee on probation; suspend a license or racing privileges; revoke a license; exclude from grounds under the jurisdiction of the commission.

(g) The stewards may order that a person be ineligible for licensing; or they may deny a license to an applicant on grounds set forth in the act or these rules.

(h) The stewards shall submit a written report to the commission of every inquiry and hearing.

(i) A stewards' ruling shall not prevent the commission from imposing a more severe penalty.

(j) The stewards may refer any matter to the commission and may include recommendations for disposition. The absence of a steward's referral shall not preclude commission action in any matter.

(k) Purses, prizes, awards, and trophies shall be redistributed if the stewards or commission order a change in the official order of finish.

(l) All fines imposed by the stewards shall be paid to the commission within 30 days after the ruling is issued, unless otherwise ordered.

(4) Protests, objections, and complaints. The stewards shall investigate promptly and render a decision in every protest, objection and complaint made to them. They shall maintain a record of all protests, objections and complaints. The stewards shall file daily with the commission a copy of each protest, objection or complaint and any related ruling.

(5) Stewards' presence. Three stewards shall be present in the stewards' stand during the running of each race.

(6) Order of finish for pari-mutuel wagering.

(a) The stewards shall determine the official order of finish for each race in accordance with 15.2.5 NMAC.

(b) The decision of the stewards as to the official order of finish, including the disqualification of a horse or horses as a result of any event occurring during the running of the race, shall be final for purposes of distribution of the pari-mutuel wagering pool.

(7) Cancel wagering. The stewards have the authority to cancel wagering on an individual betting interest or on an entire race and also have the authori-

ty to cancel a pari-mutuel pool for a race or races, if such action is necessary to protect the integrity of pari-mutuel wagering.

(8) Records and reports.

(a) The stewards shall prepare a daily report, on a form approved by the commission, detailing their actions and observations made during each day's race program. The report shall contain the name of the racetrack, the date, the weather and track conditions, claims, inquiries, and objections and any unusual circumstances or conditions. The report shall be signed by each steward and be filed with the commission not later than 24 hours after the end of each race day.

(b) The stewards shall maintain a detailed log of the stewards' official activities. The log shall describe all questions, disputes, protests, complaints, or objections brought to the attention of the stewards and all interviews, investigations and rulings made by the stewards. The log shall be available at all times for inspection by the commission or its designee.

(c) Not later than seven days after the last day of a race meeting, the stewards shall submit to the commission a written report regarding the race meeting. The report shall contain: the stewards' observations and comments regarding the conduct of the race meeting and the overall conditions of the association grounds during the race meeting; any recommendations for improvement by the association or action by the commission.

(9) Stewards' list.

(a) The stewards shall maintain a stewards' list of the horses which are ineligible to be entered in a race because of poor or inconsistent performance or behavior on the racetrack that endangers the health or safety of other participants in racing.

(b) The stewards may place a horse on the stewards' list when there exists a question as to the exact identification or ownership of said horse.

(c) A horse which has been placed on the stewards' list because of inconsistent performance or behavior, may be removed from the stewards' list when, in the opinion of the stewards, the horse can satisfactorily perform competitively in a race without endangering the health or safety of other participants in racing.

(d) A horse which has been placed on the stewards' list because of questions as to the exact identification or ownership of said horse, may be removed from the stewards' list when, in the opinion of the stewards, proof of exact identification and/or ownership has been established.

C. Racing secretary.

(1) General authority. The racing secretary shall be responsible for the programming of races during the race meeting, compiling and publishing condition books, assigning weights for handicap races, and shall receive all entries, subscriptions, declarations and scratches.

(2) Foal, health and other eligibility certificates. The racing secretary shall be responsible for receiving, inspecting and safeguarding the foal and health certificates and other documents of eligibility for all horses competing at the track or stabled on the grounds.

(3) Allocation of stalls.

(a) The racing secretary shall assign stall applicants such stabling as is deemed proper and maintain a record of arrivals and departures of all horses stabled on association grounds.

(b) Stall approvals shall be determined by: each track's screening rule as approved by the New Mexico racing commission; consideration given to stables with a balanced application; and, New Mexico breds on each application shall have preference over horses of comparable quality.

(4) Conditions.

(a) The racing secretary shall establish the conditions and eligibility for entering races and cause them to be published to owners, trainers and the commission and be posted in the racing secretary's office.

(b) For the purpose of establishing conditions, winnings shall be considered to include all monies won up to the time of the start of a race.

(c) Winnings during the year shall be calculated by the racing secretary from the preceding January 1.

(d) A minimum of two (2) races, one for quarter horses and one for thoroughbreds restricted to registered New Mexico bred horses, shall be offered daily in the condition book excluding trials.

(5) Listing of horses. The racing secretary shall: examine all entry blanks and declarations to verify information as set forth therein; select the horses to start and the also eligible horses from the declarations in accordance with these rules.

(6) Posting of entries. Upon completion of the draw each day, the racing secretary shall post a list of entries in a conspicuous location in his/her office and make the list available to the media. If the racing secretary declares a race off, the names of entrants in that race shall be posted on the official bulletin board that day, identifying the race by number as it appears in the condition book.

(7) Daily program. The racing secretary shall publish the official daily program, ensuring the accuracy therein of the following information: sequence of races to be run and post time for the first race; purse, conditions and distance for each race, and current track record for such distance; the name of licensed owners of each horse, indicated as leased, if applicable, and description of racing colors to be carried; the name of the trainer and the name of the jockey named for each horse together with the weight to be carried; the post position and saddle cloth number or designation for each horse if there is a variance with the saddle cloth designation; identification of each horse by name, color, sex, age, sire and dam; such other information as may be requested by the association or the commission.

(8) Nominations and declarations. The racing secretary shall examine nominations and declarations and early closing events, late closing events and stakes events to verify the eligibility of all declarations and nominations and compile lists thereof for publication.

(9) Stakes and entrance money records: The racing secretary shall be caretaker of the permanent records of all stakes and shall verify that all entrance monies due are paid prior to entry for races conducted at the meeting.

D. Horsemen's bookkeeper.

(1) General authority. The horsemen's bookkeeper shall maintain the records and accounts and perform the duties described herein and maintain such other records and accounts and perform such other duties as the association and commission may prescribe.

(2) Records.

(a) The records shall include the name, mailing address, social security number or federal tax identification number, and the state or country of residence of each horse owner, trainer or jockey participating at the race meeting who has funds due or on deposit in the horsemen's account.

(b) The records shall include a file of all required statements of partnerships, syndicates, corporations, assignments of interest, lease agreements and registrations of authorized agents.

(c) All records of the horsemen's bookkeeper shall be kept separate and apart from the records of the association.

(d) All records of the horsemen's bookkeeper including records of accounts and monies and funds kept on deposit are subject to inspection by the commission at any time.

(e) The association licensee is subject to disciplinary action by the commission for any violations of or non-compliance with the provisions of this rule.

(3) Monies and funds on account.

(a) All monies and funds on account with the horsemen's bookkeeper shall be maintained: separate and apart from monies and funds of the association; in

a trust account designed as "Horsemen's Trust Account"; in an account insured by the Federal Deposit and Insurance Corporation or the Federal Savings and Loan Insurance Corporation.

(b) The horsemen's bookkeeper shall be bonded in accordance with commission stipulations.

(4) Payment of purses.

(a) The horsemen's bookkeeper shall receive, maintain and disburse the purses of each race and all stakes, entrance money, jockey fees, purchase money in claiming races, along with all applicable taxes and other monies that properly come into his/her possession in accordance with the provision of commission rules.

(b) The horsemen's bookkeeper may accept monies due belonging to other organizations or recognized meetings, provided prompt return is made to the organization to which the money is due.

(c) The horsemen's bookkeeper shall disburse the purse of each race and all stakes, entrance money, jockey fees and purchase money in claiming races, along with all applicable taxes, upon request, within 48 hours of the completion of the race with respect to all horses not tested and when no timely appeal has been filed, and where a horse been tested within forty-eight (48) hours of receipt of notification that all tests with respect to such races have cleared the drug testing laboratory(ies) as reported by the stewards or the commission, except that minimum jockey mount fees may be disbursed prior to notification that the tests have cleared the testing laboratory(ies).

(d) Absent a prior request, the horsemen's bookkeeper shall disburse monies to the persons entitled to receive same within fifteen (15) days after the last race day of the race meeting, including purses for official races, provided that all tests with respect to such races have cleared the drug testing laboratory(ies) as reported by the stewards, and provided further that no protest or appeal has been filed with the stewards or the commission.

(e) In the event a protest or appeal has been filed with the stewards or the commission, the horsemen's bookkeeper shall disburse the purse within forty-eight (48) hours of receipt of dismissal or a final non-appealable order disposing of such protest or appeal.

E. Paddock judge.

(1) General authority. The paddock judge shall:

(a) supervise the assembly of horses in the paddock before the scheduled post time for each race;

(b) maintain a written record of all equipment[~~,~~];

(c) insure all horses running are properly equipped with a nylon rein or a safety rein (a safety rein is a rein with a nylon cord stitched into the traditional leather rein during the manufacturing process and the safety cord is attached to the bit with a metal clasp);

(d) inspect all equipment of each saddled and report any change thereof to the stewards;

(e) prohibit any change of equipment without the approval of the stewards;

(f) ensure that the saddling of all horses is orderly, open to public view, free from public interference, and that horses are mounted at the same time, and leave the paddock for the post in proper sequence;

(g) supervise paddock schooling of all horses approved for such by the stewards;

(h) report to the stewards any observed cruelty to a horse; ensure that only properly authorized persons are permitted in the paddock; report to the stewards any unusual or illegal activities.

(2) Paddock judge's list.

(a) The paddock judge shall maintain a list of horses which shall not be entered in a race because of poor or inconsistent behavior in the paddock that endangers the health or safety of other participants in racing.

(b) At the end of each race day, the paddock judge shall provide a copy of the list to the stewards.

(c) To be removed from the paddock judge's list, a horse must be schooled in the paddock and demonstrate to the satisfaction of the paddock judge and the stewards that the horse is capable of performing safely in the paddock.

F. Horse identifier.

(1) General authority. The horse identifier shall: when required, ensure the safekeeping of registration certificates and racing permits for horses stabled and/or racing on association grounds; inspect documents of ownership, eligibility, registration or breeding necessary to ensure the proper identification of each horse scheduled to compete at a race meeting; examine every starter in the paddock for sex, color, markings and lip tattoo or other approved method of positive identification, for comparison with its registration certificate to verify the horse's identity; supervise the tattooing, branding or other approved method of positive identification, for identification of any horse located on association grounds. Positive identification may include verification that the breed registration certificate has been submitted for correction or verification that the tattooing process has been initiated.

(2) Report violations. The horse identifier shall report to the stewards any horse not properly identified or whose registration certificate is not in conformity with these rules.

G. Clerk of scales. The clerk of scales shall: verify the presence of all jockeys in the jockeys' room at the appointed time; verify that all such jockeys have a current jockey's license issued by the commission; verify the correct weight of each jockey at the time of weighing out and weighing in and report any discrepancies to the stewards immediately; oversee the security of the jockeys' room including the conduct of the jockeys and their attendants; promptly report to the stewards any infraction of the rules with respect to weight, weighing, riding equipment or conduct; record all required data on the scale sheet and submit that data to the horsemen's bookkeeper at the end of each race day; maintain the record of applicable winning races on all apprentice certificates at the meeting; release apprentice jockey certificates, upon the jockey's departure or upon the conclusion of the race meet; assume the duties of the jockey room custodian in the absence of such employee.

H. Jockey room custodian. The jockey room custodian shall: supervise the conduct of the jockeys and their attendants while they are in the jockey room; keep the jockey room clean and safe for all jockeys; ensure all jockeys are in the correct colors before leaving the jockey room to prepare for mounting their horses; keep a daily film list as displayed in plain view for all jockeys; keep a daily program displayed in plain view for the jockeys so they may have ready access to mounts that may become available; allow only authorized or licensed persons access to the jockey room; for the purposes of this subsection, authorized persons are jockeys, jockey attendants, jockey room employees, starting gate personnel, track physician, stewards, commissioners and their duly authorized representatives, and such other persons who in the determination of the stewards have a legitimate purpose or need related to the conduct of racing that requires that they have access to the jockey room; report to the stewards any unusual occurrences in the jockey room; and, ensure all jockey's whips are in compliance with Paragraph (1) of Subsection A of 15.2.5.13 NMAC.

I. Starter.

(1) General authority. The starter shall: have complete jurisdiction over the starting gate, the starting of horses and the authority to give orders not in conflict with the rules as may be required to ensure all participants an equal opportunity to a fair start; appoint and supervise assistant starters who have demonstrated they are adequately trained to safely handle horses in the starting gate; in emergency situations, the starter may appoint qualified indi-

viduals to act as substitute assistant starters; assign the starting gate stall positions to assistant starters by lot and notify the assistant starters prior to post time for the first race of their respective stall positions which will remain that assistant starter's position throughout the day; there shall be no changes except with permission of the stewards; assess the ability of each person applying for a jockey's license in breaking from the starting gate and working a horse in the company of other horses, and shall make said assessment known to the stewards; load horses into the gate in any order deemed necessary to ensure a safe and fair start.

(2) Assistant starters. With respect to an official race, the assistant starters shall not: handle or take charge of any horse in the starting gate without the expressed permission of the starter; impede the start of a race; apply any device, without the approval of the stewards to assist in loading a horse into the starting gate; slap, boot or otherwise dispatch a horse from the starting gate; strike or use abusive language to a jockey; accept or solicit any gratuity or payment other than his/her regular salary, directly or indirectly, for services in starting a race.

(3) Starter's list. No horse shall be permitted to start in a race unless approval is given by the starter. The starter shall maintain a starter's list of all horses which are ineligible to be entered in any race because of poor or inconsistent behavior or performance in the starting gate. Such horse shall be refused entry until it has demonstrated to the starter that it has been satisfactorily schooled in the gate and can be removed from the starter's list. Schooling shall be under the supervision of the starter.

(4) Report violations. The starter and assistant starter shall report all unauthorized activities to the stewards.

J. Timer/clocker.

(1) General authority (timer).

(a) The timer shall accurately record the time elapsed between the start and finish of each race.

(b) The time shall be recorded from the instant that the first horse leaves the point from which the distance is measured until the first horse reaches the finish line.

(c) At the end of a race, the timer shall post the official running time on the infield totalisator board on instruction by the stewards.

(d) At a racetrack equipped with an appropriate infield totalisator board, the timer shall post the quarter times (splits) for thoroughbred races in fractions as a race is being run. For quarter horse races, the timer shall post the official times in hundredths of a second.

(e) For back-up purposes, the timer shall also use a stopwatch to time all races. In time trials, the timer shall ensure that three stopwatches are used by the stewards or their designees.

(f) The timer shall maintain a written record of fractional and finish times of each race and have same available for inspection by the stewards or the commission on request.

(2) General authority (clocker).

(a) The clocker shall be present during training hours at each track on association grounds, which is open for training, to identify each horse working out and to accurately record the distances and times of each horse's workout.

(b) Each day, the clocker shall prepare a list of workouts that describes the name of each horse which worked along with the distance and time of each horse's workout.

(c) At the conclusion of training hours, the clocker shall deliver a copy of the list of workouts to the stewards and the racing secretary.

K. Patrol judge. The patrol judge, when utilized, is responsible for observing the race and reporting information concerning the race to the stewards. If the track's video replay system is deemed adequate, use of patrol judges is optional.

L. Gate judge. The commission may require each track to employ a gate judge whose duties shall include being present at the starting gate just prior to the running of each race to observe and report any violations of the rules to the stewards, and to otherwise assist the stewards as they may so order.

M. Placing judge.

(1) General authority. The placing judges shall determine the order of finish in a race as the horses pass the finish line, and with the approval of the stewards, may display the results of the totalisator board.

(2) Photo finish.

(a) In the event the placing judges or the stewards request a photo of the finish, the photo finish shall be posted on the totalisator board.

(b) Following their review of the photo finish film strip, the placing judges shall, with the approval of the stewards, determine the exact order of finish for all horses participating in the race, and shall immediately post the numbers of the first four finishers on the totalisator board.

(c) In the event a photo was requested, the placing judges shall cause a photographic print of said finish to be produced. The finish photograph shall, when needed, be used by the placing judges as an aid in determining the correct order of finish.

(d) Upon determination of the correct order of finish of a race in which the placing judges have utilized a photographic print to determine the first four finishers, the stewards shall cause prints of said photograph to be displayed publicly in the grandstand and clubhouse areas of the racetrack.

(3) Dead heats.

(a) In the event the placing judges determine that two or more horses finished the race simultaneously and cannot be separated as to their order of finish, a dead heat shall, with the approval of the stewards, be declared.

(b) In the event one or more of the first four finishers of a race are involved in a dead heat, the placing judges shall post the dead heat sign on the totalisator board and cause the numbers of the horse or horses involved to blink on the totalisator board.

N. Official veterinarian. The official veterinarian shall:

(1) be employed by the commission;

(2) be a graduate veterinarian and be licensed to practice in the state;

(3) recommend to the stewards any horse deemed unsafe to be raced, or a horse that it would be inhumane to allow to race;

(4) supervise the taking of all specimens for testing according to procedures approved by the commission;

(5) provide proper safeguards in the handling of all laboratory specimens to prevent tampering, confusion or contamination;

(6) have the authority and jurisdiction to supervise the practicing licensed veterinarians within the enclosure;

(7) report to the commission the names of all horses humanely destroyed or which otherwise expire at the meeting and the reasons therefore;

(8) refuse employment or payment, directly or indirectly, from any horse owner or trainer of a horse racing or intending to race in this jurisdiction while employed as the official veterinarian for the commission;

(9) place horses on the bleeder list and remove horses from the bleeder list; and

(10) be authorized to humanely destroy any horse deemed to be so seriously injured that it is in the best interests of racing the horse to so act.

O. Racing veterinarian.

(1) General authority. At the discretion of the commission, the racing veterinarian may be an employee of the commission. At the discretion of the commission, the duties of the racing veterinarian may be assumed by the official veterinarian.

(2) The association may employ an additional racing veterinarian in

order to further ensure the safety of racing.

(3) The racing veterinarian shall:

(a) be directly responsible to the official veterinarian;

(b) be a graduate veterinarian and be licensed to practice in the state;

(c) be available to the racing secretary and/or the stewards prior to scratch time each racing day, at a time designated by the stewards, to inspect any horses and report on their condition as may be requested by the stewards;

(d) be present in the paddock during saddling, on the racetrack during the post parade and at the starting gate until the horses are dispatched from the gate for the race;

(e) inspect any horse when there is a question as to the physical condition of such horse;

(f) recommend scratching a horse to the stewards if, in the opinion of the racing veterinarian, the horse is physically incapable of exerting its best effort to win;

(g) inspect any horse which appears in physical distress during the race or at the finish of the race; and shall report such horse together with his/her opinion as to the cause of the distress to the stewards and to the official veterinarian;

(h) refuse employment or payment, directly or indirectly, from any horse owner or trainer of a horse racing or intending to race in this jurisdiction while employed as the official veterinarian for the commission;

(i) refrain from directly treating or prescribing for any horse scheduled to participate during his/her term of appointment at any recognized meeting except in cases of emergency, accident or injury;

(j) be authorized to humanely destroy any horse deemed to be so seriously injured that it is in the best interests of racing to so act;

(k) conduct soundness inspections on horses participating in races at the meeting; and

(l) with approval of the official veterinarian, place horses on the bleeders list.

(4) The racing veterinarian shall place horses on the veterinarian's list, when necessary, and may remove from the list those horses which are, in the racing veterinarian's opinion, able to satisfactorily compete in a race.

(5) The racing veterinarian shall be present at the office of the racing secretary and/or stewards prior to scratch time each racing day at a time designated by the stewards, to inspect any horses and report on their condition as may be requested by the stewards.

(6) Veterinarian's list.

(a) The racing veterinarian shall maintain a list of all horses which are determined to be unfit to compete in a race due to physical distress, unsoundness, infirmity or medical condition.

(b) A horse may be removed from the veterinarian's list when, in the opinion of the racing veterinarian, the horse has satisfactorily recovered the capability of performing in a race.

P. Any other person designated by the commission. The commission may create additional racing official positions, as needed. Persons selected for these positions shall be considered racing officials and shall be subject to the general eligibility requirements outlined in Subsection A of 15.2.3 NMAC.

[15.2.3.8 NMAC - Rp, 15 NMAC 2.3.8, 04/13/2001; A, 11/15/2001; A, 08/30/2007; A, 06/15/09; A, 06/30/09]

NEW MEXICO RACING COMMISSION

This is an amendment to Subsection F of 15.2.4.8 NMAC, effective 06/30/09.

15.2.4.8 CLAIMING RACES:

A. GENERAL PROVISIONS:

(1) A person entering a horse in a claiming race warrants that the title to said horse is free and clear of any existing claim or lien, either as security interest mortgage, bill of sale, or lien of any kind; unless before entering such horse, the written consent of the holder of the claim or lien has been filed with the stewards and the racing secretary and its entry approved by the stewards. A transfer of ownership arising from a recognized claiming race will terminate any existing prior lease for that horse.

(2) A filly or mare that has been bred is ineligible to enter into a claiming race unless a licensed veterinarian's certificate dated at least 25 days after the last breeding of that mare is on file with racing secretary's office stating that the mare or filly is not in foal. However, an in-foal filly or mare shall be eligible to enter into a claiming race if the following conditions are fulfilled:

(a) full disclosure of such fact is on file with the racing secretary and such information is posted in his/her office;

(b) the stallion service certificate has been deposited with the racing secretary's office (although all information obtained on such certificate shall remain confidential);

(c) all payments due for the service in question and for any live progeny resulting from that service are paid in full;

(d) the release of the stallion service certificate to the successful claimant at the time of claim is guaranteed.

(3) The stewards may set aside and order recession of a claim for any horse from a claiming race run in this jurisdiction upon a showing that any party to the claim committed a prohibited action, as specified in Subsection D of 15.2.4 NMAC with respect to the making of the claim, or that the owner of the horse at the time of entry in the claiming race failed to comply with any requirement of these rules regarding claiming races. Should the stewards order a recession of a claim, they may also, in their discretion, make a further order for the costs of maintenance and care of the horse as they may deem appropriate.

B. CLAIMING OPTION ENTRY:

(1) At the time of entry into a claiming race, the owner may opt to declare a horse ineligible to be claimed provided:

(a) the horse has been laid off and has not started for a minimum of 120 days since its last race, and;

(b) the horse is entered for a claiming price equal to or greater than the price at which it last started.

(2) Failure to declare the horse ineligible at the time of entry may not be remedied.

(3) Ineligibility shall apply only to the first start following each such layoff.

C. CLAIMING OF HORSES:

(1) Any horse in a race for claiming may not wear into the paddock anything it will not race in except for a blanket, rain sheet or halter and lead shank for control.

(2) Any horse starting in a claiming race is subject to be claimed for its entered price by any: licensed owner; holder of a valid claim certificate; licensed authorized agent acting on behalf of an eligible claimant.

(3) Every horse claimed shall race for the account of the original owner, but title to the horse shall be transferred to the claimant from the time the horse enters the track to the post. The successful claimant shall become the owner of the horse regardless of whether it is alive or dead, sound or unsound, or injured during the race or after it.

D. CLAIM CERTIFICATE:

(1) An applicant for a claim certificate shall submit to the commission: an application for an owner's license and the required fee; the name of a licensed trainer, or person eligible to be a licensed trainer, who will assume the care and responsibility for any horse claimed.

(2) The stewards shall issue a claim certificate upon satisfactory evidence

that the applicant is eligible for an owner's license.

(3) The claim certificate shall expire 30 days after the date of issuance, or upon the claim of a horse, or upon issuance or denial of an owner's license, whichever comes first.

(4) A claim certificate may be renewed by the stewards during the same year.

E. PROHIBITIONS:

(1) A person shall not claim a horse in which the person has a financial or beneficial interest as an owner or trainer.

(2) A person shall not cause another person to claim a horse for the purpose of obtaining or retaining an undisclosed financial or beneficial interest in the horse.

(3) A person shall not enter into an agreement for the purpose of preventing another person from obtaining a horse in a claiming race.

(4) A person shall not claim a horse, or enter into any agreement to have a horse claimed, on behalf of an ineligible or undisclosed person.

F. PROCEDURE FOR CLAIMING:

(1) To make a valid claim for a horse, an eligible person shall:

(a) have on deposit with the horsemen's bookkeeper an amount equal to the amount of the claim, plus all transfer fees and applicable taxes; and for all quarter horse claims shall also have on deposit in their horsemen's account all fees for a rush transfer, not to exceed $100.00, prior to entering;

(b) complete a written claim including information that the claimant holds a current valid license on a form furnished by the association and approved by the commission;

(c) identify the horse to be claimed by the spelling of its name on the certificate of registration or as spelled on the official program;

(d) place the completed claim form inside a sealed envelope furnished by the association and approved by the commission;

(e) have the time of day that the claim is entered recorded on the envelope;

(f) have the envelope deposited in the claim box no later than 10 minutes prior to post time of the race for which the claim is entered.

(2) After a claim has been deposited in the claim box, it is irrevocable and shall not be withdrawn from the claim box.

(3) Officials and employees of the association shall not provide any information as to the filing of claims until after the horses have entered the track to post.

(4) If more than one claim is filed on a horse, the successful claim shall be determined by lot conducted by the stewards or their representatives.

(5) Notwithstanding any designation of sex or age appearing in the racing program or in any racing publication, the claimant of a horse shall be solely responsible for the determination of the sex or age of any horse claimed.

G. TRANSFER OF CLAIMED HORSES:

(1) Upon successful claim, the stewards shall issue, upon forms approved by the commission, an authorization of transfer of the horse from the original owner to the claimant. Copies of the transfer authorization shall be forwarded to and maintained by the stewards and the racing secretary. Upon notification by the stewards, the horsemen's bookkeeper shall immediately debit the claimant's account for the claiming price, applicable taxes and transfer fees.

(2) A person shall not refuse to deliver a properly claimed horse to the successful claimant.

(3) Transfer of possession of a claimed horse shall take place immediately after the race has been run unless otherwise directed by the stewards. If the horse is required to be taken to the testbarn for post-race testing, the original trainer or his/her representative shall maintain physical custody of the claimed horse and shall observe the testing procedure and sign the test sample tag. The successful claimant or his/her representative shall also accompany the horse to the testbarn.

(4) When a horse is claimed out of a claiming race, the horse's engagements are transferred, with the horse, to the claimant.

(5) Ownership interest in any horse claimed from a race shall not be resold or transferred for 30 days after such horse was claimed, except by claim from a subsequent race.

(6) A claimed horse shall not race elsewhere, except within state, or out of state stake races for a period of thirty days (30) or the end of the meet, whichever occurs first.

(7) A claimed horse shall not remain in the same stable or under the control or management of its former owner.

[15.2.4.8 NMAC - Rp, 15 NMAC 2.4.8, 03/15/2001; A, 10/31/2006; A, 06/15/2009; A, 06/30/09]

NEW MEXICO RACING COMMISSION

This is an amendment to 15.2.5 NMAC Section 13, effective 06/30/09.The subsequent paragraphs were renumbered only to accommodate for the new rule material being placed into Paragraph (3) of Subsection A of 15.2.5.13 NMAC.

15.2.5.13 RUNNING OF THE RACE:

A. EQUIPMENT.

(1) No whip shall weigh more than one pound nor exceed 31 inches in length, including the popper. No whip shall be used unless it has affixed to the end a looped popper not less than one and one-quarter (1 1/4) inches in width, and not over three (3) inches in length, and be feathered above the popper with not less than three (3) rows of feathers, each feather not less than one (1) inch in length. There shall be no holes in the popper. All whips are subject to inspection and approval by the stewards.

(2) No bridle shall exceed two pounds.

(3) Reins. No jockey, apprentice jockey, exercise person or any person mounted on a horse shall ride, breeze, exercise, gallop or workout a horse on the grounds of a facility under the jurisdiction of the commission unless the horse is equipped with a nylon rein or a safety rein. A safety rein is a rein with a wire or nylon cord stitched into the traditional leather rein during the manufacturing process and the safety cord is attached to the bit with a metal clasp.

[~~(3)~~] (4) Toe grabs with a height greater than four millimeters worn on the front shoes of quarter horses and two millimeters worn on the front shoes of thoroughbred horses while racing are prohibited. The horse shall be scratched and the trainer may be subject to fine.

[~~(4)~~] (5) A horse's tongue may be tied down with clean bandages, gauze or tongue strap.

[~~(5)~~] (6) No licensee may add blinkers to a horse's equipment or discontinue their use without the prior approval of the starter, the paddock judge, and the stewards.

[~~(6)~~] (7) No licensee may change any equipment used on a horse in its last race without approval of the paddock judge or stewards.

[~~(7)~~] (8) All jockeys and exercise riders must wear a fastened protective helmet and fastened safety vest when mounted. The safety vest shall weigh no more than two pounds and shall be designed to provide shock-absorbing protection to the upper body of at least a rating of five, as defined by the British equestrian trade association (BETA).

B. RACING NUMBERS.

(1) Each horse shall carry a conspicuous saddle cloth number corresponding to the official number given that horse on the official program.

(2) In the case of a coupled

entry that includes more than one horse, each horse in the entry shall carry the same number, with a different distinguishing letter following the number. As an example, two horses in the same entry shall appear in the official program as 1 and 1A.

(3) Each horse in the mutuel field shall carry a separate number or may carry the same number with a distinguishing letter following the number.

C. JOCKEY REQUIREMENTS.

(1) Jockeys shall report to the jockeys' quarters at the time designated by the association. Jockeys shall report their engagements and any overweight to the clerk of scales. Jockeys shall not leave the jockeys' quarters, except to ride in scheduled races, until all of their riding engagements of the day have been fulfilled except as approved by the stewards.

(2) A jockey who has not fulfilled all riding engagements, who desires to leave the jockeys' quarters, must first receive the permission of the stewards and must be accompanied by an association security guard.

(3) Except as otherwise provided by this subsection, a jockey engaged for a certain race or for a specified time may not fail or refuse to abide by the engagement agreement, unless excused by the stewards. Failure to fulfill riding engagements may result in disciplinary action.

(4) A jockey may be excused by the stewards from fulfilling the jockey's riding engagement if the jockey believes the horse he or she is to ride is unsafe, or the racecourse he or she is to ride on is unsafe, or the jockey is ill or injured, or other extenuating circumstances. In that event a jockey's fee is not earned.

(5) The stewards may require a jockey who is excused from fulfilling a riding engagement, because of illness or injury, to pass a physical examination conducted by a licensed physician not employed by the association before resuming race riding.

(6) While in the jockeys' quarters, jockeys shall have no contact or communication with any person outside the jockeys' quarters other than commission personnel and officials, an owner or trainer for whom the jockey is riding or a representative of the regular news media, except with the permission of the stewards. Any communication permitted by the stewards may be conducted only in the presence of the clerk of scales or other person designated by the stewards.

(7) Jockeys shall be weighed out for their respective mounts by the clerk of scales not more than 30 minutes before post time for each race.

(8) A jockey's fee shall be considered earned when the jockey is weighed out by the clerk of scales. In the event an owner or trainer elects to remove a jockey from his or her mount after naming a rider at the time of draw, the stewards may require a double jockey fee to be paid. The fee to be paid is equal to that earned by the jockey who rode the horse. The fee shall not be considered earned when a jockey(s), of their own free will, take themselves off their mounts, where injury to the horse or rider is not involved. Any conditions or considerations not covered by the above rule shall be at the discretion of the stewards. All jockey protests must be filed prior to the race.

(9) Only valets employed by the association shall assist jockeys in weighing out.

(10) A jockey's weight shall include his/her clothing, boots, saddle and its attachments and any other equipment except the whip, bridle, bit or reins, safety helmet, safety vest, blinkers, goggles and number cloth.

(11) Seven pounds is the limit of overweight any horse is permitted to carry.

(12) Once jockeys have fulfilled their riding engagements for the day and have left the jockeys' quarters, they shall not be re-admitted to the jockeys' quarters until after the entire racing program for that day has been completed, except with permission of the stewards.

D. PADDOCK TO POST.

(1) Each horse shall carry the full weight assigned for that race from the paddock to the starting post, and shall parade past the stewards' stand, unless excused by the stewards. The post parade shall not exceed 12 minutes, unless otherwise ordered by the stewards. It shall be the duty of the stewards to ensure that the horses arrive at the starting gate as near to post time as possible.

(2) In the post parade, all pony persons, or trainers who pony horses, must wear upper body apparel in accordance with the policy of the commission.

(3) After the horses enter the track, no jockey may dismount nor entrust his horse to the care of an attendant unless, because of accident occurring to the jockey, the horse or the equipment, and with the prior consent of the starter. During any delay during which a jockey is permitted to dismount, all other jockeys may dismount and their horses may be attended by others. After the horses enter the track, only the jockey, an assistant starter, the official veterinarian, the racing veterinarian or an outrider or pony rider may touch the horse before the start of the race.

(4) If a jockey is seriously injured on the way to the post, the horse may be returned to the paddock and a replacement jockey obtained.

(5) After passing the stewards' stand in parade, the horses may break formation and proceed to the post in any manner unless otherwise directed by the stewards. Once at the post, the horses shall be started without unnecessary delay.

(6) In case of accident to a jockey or his/her mount or equipment, the stewards or the starter may permit the jockey to dismount and the horse to be cared for during the delay, and may permit all jockeys to dismount and all horses to be attended to during the delay.

(7) If a jockey is thrown on the way from the paddock to the post, the horse must be remounted, returned to the point where the jockey was thrown and then proceed over the route of the parade to the post. The horse must carry its assigned weight from paddock to post and from post to finish.

(8) If a horse leaves the course while moving from paddock to post, the horse shall be returned to the course at the nearest practical point to that at which it left the course, and shall complete its parade to the post from the point at which it left the course unless ordered scratched by the stewards.

(9) No person shall willfully delay the arrival of a horse at the post.

(10) The starter shall load horses into the starting gate in any order deemed necessary to ensure a safe and fair start. An appointed representative may tail the horse with the starter's consent. In case of an emergency, the starter may grant approval

for a horse to be tailed. In any case, the steward's shall be notified of who is tailing horses.

E. POST TO FINISH.

(1) The start.

(a) The starter is responsible for assuring that each participant receives a fair start.

(b) If, when the starter dispatches the field, any door at the front of the starting gate stalls should not open properly due to a mechanical failure or malfunction or should any action by any starting personnel directly cause a horse to receive an unfair start, the stewards may declare such a horse a non-starter.

(c) Should a horse, not scratched prior to the start, not be in the starting gate stall thereby causing it to be left when the field is dispatched by the starter, the horse shall be declared a non-starter by the stewards.

(d) Should an accident or malfunction of the starting gate, or other unforeseeable event compromise the fairness of the race or the safety of race participants, the stewards may declare individual horses to be non-starters, exclude individual horses from one or more pari-mutuel pools or declare a "no contest" and refund all wagers except as otherwise provided in the rules involving multi-race wagers.

(2) Interference, jostling or striking.

(a) A jockey shall not ride carelessly or willfully so as to permit his/her mount to interfere with, impede or intimidate any other horse in the race.

(b) No jockey shall carelessly or willfully jostle, strike or touch another jockey or another jockey's horse or equipment.

(c) No jockey shall unnecessarily cause his/her horse to shorten its stride so as to give the appearance of having suffered a foul.

(3) Maintaining a straight course.

(a) When the way is clear in a race, a horse may be ridden to any part of the course, but if any horse swerves, or is ridden to either side, so as to interfere with, impede or intimidate any other horse, it is a foul.

(b) The offending horse may be disqualified, if in the opinion of the stewards, the foul altered the finish of the race, regardless of whether the foul was accidental, willful or the result of careless riding.

(c) If the stewards determine the foul was intentional, or due to careless riding, they may fine or suspend the guilty jockey.

(d) In a straightaway race, every horse must maintain position as nearly as possible in the lane in which it starts. If a horse is ridden, drifts or swerves out of its lane in such a manner that it interferes with, impedes or intimidates another horse, it is a foul and may result in the disqualification of the offending horse.

(4) Disqualification.

(a) When the stewards determine that a horse shall be disqualified for interference, they may place the offending horse behind such horse as in their judgment it interfered with, or they may place it last.

(b) If a horse is disqualified for a foul, any horse or horses with which it is coupled as an entry may also be disqualified.

(c) When a horse is disqualified for interference in a time trial race, it shall receive the time of the horse it is placed behind plus one-hundredth of a second penalty or more exact measurement if photo finish equipment permits, and shall be eligible to qualify for the finals or consolations of the race on the basis of the assigned time.

(d) The stewards may determine that a horse shall be unplaced for the purpose of purse distribution and trial qualification.

(e) In determining the extent of disqualification, the stewards in their discretion may: declare null and void a track record set or equaled by a disqualified horse, or any horses coupled with it as an entry; affirm the placing judges' order of finish and suspend or fine a jockey if, in the stewards' opinion, the foul riding did not affect the order of finish; disqualify the offending horse and not penalize a jockey if in the stewards' opinion the interference to another horse in a race was not the result of an intentional foul or careless riding on the part of a jockey.

(5) Horses shall be ridden out: All horses shall be ridden out in every race. A jockey shall not ease up or coast to the finish, without adequate cause, even if the horse has no apparent chance to win prize money.

(6) Use of whips.

(a) Although the use of a whip is not required, any jockey who uses a whip during a race shall do so only in a manner consistent with exerting his/her best efforts to win.

(b) In all races where a jockey will ride without a whip, an announcement of such fact shall be made over the public address system.

(c) No electrical or mechanical device or other expedient designed to increase or retard the speed of a horse, other than the ordinary whip approved, shall be possessed by anyone, or applied by anyone to the horse at any time on the grounds of the association during the meeting, whether in a race or otherwise.

(d) Whips shall not be used on two-year-old horses before March 1 of each year.

(e) Indiscriminate use of the whip is prohibited including whipping a horse: on the head, flanks or on any other part of its body other than the shoulders or hind quarters; during the post parade except when necessary to control the horse; excessively or brutally causing welts or breaks in the skin; when the horse is clearly out of the race or has obtained its maximum placing; persistently even though the horse is showing no response under the whip.

(7) Horse leaving the racecourse. If a horse leaves the racecourse during a race, it must turn back and resume the race from the point at which it originally left the course.

(8) Returning after the finish.

(a) After a race has been run, the jockey shall ride promptly to the finish line, dismount and report to the clerk of scales to be weighed in. Jockeys shall weigh in with all pieces of equipment with which they weighed out.

(b) If a jockey is prevented from riding to the finish line because of an accident or illness to the jockey or the horse, the jockey may walk or be transported to the scales, or may be excused from weighing in by the stewards.

(9) Unsaddling. No person shall assist a jockey with unsaddling except with permission of the stewards and no one shall place a covering over a horse before it is unsaddled.

(10) Weighing in.

(a) A jockey shall weigh in at the same weight at which he/she weighed out, and if under that weight by more than two pounds, his/her mount shall be disqualified from any portion of the purse money.

(b) In the event of such disqualification, all monies wagered on the horse shall be refunded unless the race has been declared official.

(c) If any jockey weighs in at more than two pounds over the proper or declared weight, the jockey shall be fined or suspended or ruled off by the stewards, having due regard for any excess weight caused by rain or mud. The case shall be reported to the commission for such action, as it may deem proper.

(11) Dead heats.

(a) When a race results in a dead heat, the dead heat shall not be run off, owners shall divide except where division would conflict with the conditions of the races.

(b) When two horses run a dead heat for first place, all purses or prizes to which first and second horses would have been entitled shall be divided equally between them; and this applies in dividing all purses or prizes whatever the number of horses running a dead heat and whatever places for which the dead heat is run.

(c) In a dead heat for first place, each horse involved shall be deemed a winner and liable to penalty for the amount it shall receive.

(d) When a dead heat is run for second place and an objection is made to the winner of the race, and sustained, the horses, which ran a dead heat, shall be deemed to have run a dead heat for first place.

(e) If the dividing owners cannot agree as to which of them is to have a cup or other prize, which cannot be divided, the question shall be determined by lot by the stewards.

(f) On a dead heat for a match, the match is off for pari-mutuel payoffs and mutuels are refunded.

[15.2.5.13 NMAC - Rp, 15 NMAC 2.5.13, 03/15/2001; A, 08/30/2007; A, 12/01/08; A, 06/30/09]

NEW MEXICO RACING COMMISSION

Explanatory Paragraph: This is an amendment to Subsection D of Section 9 of 15.2.6 NMAC, clarifying the levels in therapeutic medications allowed in urine specimens for race horses that determine a violation, effective 06/30/09.

15.2.6.9 MEDICATIONS AND PROHIBITED SUBSTANCES:

. . .

D. PENALTY RECOMMENDATIONS (in the absence of mitigating circumstances).

(1) A written warning for one positive test within a 12-month period in the following levels:

(a) 5.1 micrograms per milliliter to 9.9 micrograms per milliliter in one drug of phenylbutazone or oxyphenbutazone; or

(b) 1.1 microgram per milliliter to 1.3 microgram per milliliter of flunixin; or

(c) 1.1 microgram per milliliter to 1.3 microgram per milliliter of meclofenamic acid;

(d) 50.0 to 60.0 nanograms per milliliter of ketoprofen.

(2) A fine for one positive test within a 12-month period in the following levels:

(a) $200 for 10.0 micrograms per milliliter and above for combined total amount of phenylbutazone and oxyphenbutazone; or

(b) $200 for more than 1.3 micrograms per milliliter of flunixin; or

(c) $200 for more than 1.3 micrograms per milliliter of meclofenamic acid; or

(d) $300 for 5.1 micrograms per milliliter or more of either phenylbutazone or oxyphenbutazone in combination with 1.3 micrograms or more of either flunixin or meclofenamic acid; or

(e) $200 for 5.6 to 5.9 micrograms per milliliter in one drug of phenylbutazone, or oxyphenbutazone, and 1.1 to 1.2 micrograms per milliliter of flunixin or meclofenamic acid;

(f) $200 for [~~75.0~~] more than 60.0 nanograms per milliliter of ketoprofen.

(3) The penalties for a second violation within a twelve-month period are as follows:

(a) a second violation of Paragraph (1) of this subsection shall be a fine of $200;

(b) a second violation of Paragraphs 2(a), 2(b), or 2(c) of this subsection shall be a fine of $400;

(c) a second violation of Paragraph 2(d) of this subsection shall be a fine of $600;

(d) a second violation of Paragraph 2(e) of this subsection shall be a fine of $400;

(e) a second violation of Paragraph 2(f) of this subsection shall be a fine of $400.

(4) The penalties for a third violation within a twelve-month period are as follows:

(a) a third violation of Paragraph (1) of this subsection shall be a fine of $400;

(b) a third violation of Paragraphs 2(a), 2(b), or 2(c) of this subsection shall be a $400 fine, disqualification, and loss of purse;

(c) a third violation of Paragraph 2(d) of this subsection shall be a fine of $900, disqualification, and loss of purse;

(d) a third violation of Paragraph 2(e) of this subsection shall be a fine of $900, disqualification, and loss of purse;

(e) a third violation of Paragraph 2(f) of this subsection shall be a fine of $900, disqualification, and loss of purse.

(5) The penalties for a fourth violation within a twelve-month period are as follows:

(a) a fourth violation of Paragraph (1) of this subsection shall be a fine of $400, disqualification, and loss of purse;

(b) a fourth violation of Paragraphs 2(a), 2(b), or 2(c) of this subsection shall be a fine of $1,000, loss of purse, disqualification, and a thirty day suspension;

(c) a fourth violation of Paragraph 2(d) of this subsection shall be a fine of $1,500, loss of purse, disqualification, and a thirty-day suspension;

(d) a fourth violation of Paragraph 2(e) of this subsection shall be a fine of $1,500, loss of purse, disqualification, and a thirty-day suspension;

(e) a fourth violation of Paragraph 2(f) of this subsection shall be a fine of $1,500, loss of purse, disqualification, and a thirty-day suspension.

(6) For the fifth violation within a 12 month period of Paragraph (1) of this subsection shall be a fine of $1,000, loss of purse, disqualification, and a thirty day suspension.

(7) A positive test of two permitted non-steroidal anti-inflammatory drugs found at twice the allowable level or more for two drugs shall carry the penalties of a class IV drug positive for the trainer and attending veterinarian. Additional violations shall carry the same penalties as additional violations of a class IV drug for the trainer and the attending veterinarian.

[15.2.6.9 NMAC - Rp, 15 NMAC 2.6.9, 04/13/2001; A, 08/30/2001; A, 07/15/2002; A, 08/15/2002; A, 09/29/2006; A, 10/31/2006; A, 08/30/2007; A, 01/31/2008; A, 03/01/2009; A, 06/15/09; A, 06/30/09]

NEW MEXICO RACING COMMISSION

This is an amendment to 16.47.1 NMAC Section 10, effective date 06/30/09. Corrections to the numeration of paragraphs within Subsection C were also made.

16.47.1.10 TRAINERS

A. ELIGIBILITY.

(1) An applicant for a license as trainer or assistant trainer must be at least 18 years of age; be qualified, as determined by the stewards or other commission designee, by reason of experience, background and knowledge of racing; a trainer's license from another jurisdiction, having been issued within a 24 month period by the commission, may be accepted as evidence of experience and qualifications; evidence of qualifications may require passing one or more of the following: a written examination; an interview or oral examination; a demonstration of practical skills in a barn test given by a committee of trainers appointed by the New Mexico Horsemen's Association and approved by the commission.

(2) Applicants not previously licensed as a trainer shall be required to pass a written/oral examination, demonstrate practical skills, and submit at least two written statements as to the character and qualifications of the applicant, and documentation of having completed a six month apprenticeship under the direct supervision of a licensed trainer or assistant trainer.

(a) Applicants failing the first

written/oral examination must wait thirty (30) days before retaking the trainer's test.

(b) Applicants failing the second written/oral examination must wait sixty (60) days before retaking the trainer's test.

(c) Applicants failing the third written/oral examination must wait one (1) year before retaking the trainer's test.

B. ABSOLUTE INSURER.

(1) The trainer is the absolute insurer of the condition of horses entered in an official workout or race and is responsible for the presence of any prohibited drug or medication, or other prohibited substance in such horses. A positive test for a prohibited drug or medication or other prohibited substance or the presence of permitted medication in excess of maximum allowable levels as reported by a commission-approved laboratory is prima facie evidence of a violation of this rule. The trainer is absolutely responsible regardless of the acts of third parties.

(2) A trainer must prevent the administration of any drug or medication or other prohibited substance that may cause a violation of these rules.

(3) A trainer whose horse has been claimed remains the absolute insurer for the race in which the horse is claimed.

C. OTHER RESPONSIBILITY. A trainer is responsible for:

(1) the condition and contents of stalls, tack rooms, feed rooms, sleeping rooms and other areas which have been assigned by the association;

(2) maintaining the assigned stable area in a clean, neat, and sanitary condition at all times;

(3) ensuring that fire prevention rules are strictly observed in the assigned stable area;

(4) providing a list to the chief of security of the trainer's employees on association grounds and any other area under the jurisdiction of the commission; the list shall include each employee's name, occupation, social security number, and occupational license number; the chief of security shall be notified by the trainer, in writing, within 24 hours of any change;

(5) the proper identity, custody, care, health, condition, and safety of horses in his/her charge;

(6) disclosure of the true and entire ownership of each horse in his/her care, custody or control; any change in ownership must be reported immediately to, and approved by, the stewards and recorded by the racing secretary;

(7) training all horses owned wholly or in part by him/her which are participating at the race meeting; registering with the racing secretary each horse in his/her charge within 24 hours of the horse's arrival on association grounds;

(8) immediately notify the stewards and commission veterinarian of all out-of-state certified horses on **Salix®**;

(9) having each horse in his/her care that is racing, or is stabled on association grounds, tested for equine infectious anemia (EIA) and for filing evidence of such negative test results with the racing secretary as required by the commission;

[~~(11)~~] (10) using the services of those veterinarians licensed by the commission to attend horses that are on association grounds;

[~~(12)~~] (11) immediately reporting the alteration in the sex of a horse in his/her care to the horse identifier and the racing secretary, whose office shall note such alteration on the certificate of registration;

[~~(13)~~] (12) promptly reporting to the racing secretary and the official veterinarian any horse on which a posterior digital neurectomy (heel nerving) is performed and ensuring that such fact is designated on its certificate of registration;

[~~(14)~~] (13) promptly notifying the official veterinarian of any reportable disease and any unusual incidence of a communicable illness in any horse in his/her charge;

[~~(15)~~] (14) promptly reporting the death of any horse in his/her care on association grounds to the stewards and the official veterinarian and compliance with the rules in Subsection C of 15.2.6.12 NMAC governing post-mortem examinations;

[~~(16)~~] (15) maintaining a knowledge of the medication record and status of all horses in his/her care;

[~~(17)~~] (16) immediately reporting to the stewards and the official veterinarian if he/she knows, or has cause to believe, that a horse in his/her custody, care or control has received any prohibited drugs or medication;

[~~(18)~~] (17) representing an owner in making entries and scratches and in all other matters pertaining to racing; horses entered as to eligibility and weight or other allowances claimed;

[~~(19)~~] (18) horses entered as to eligibility and weight or other allowances claimed;

[~~(20)~~] (19) ensuring the fitness of a horse to perform creditably at the distance entered;

[~~(21)~~] (20) ensuring that his/her horses are properly shod, bandaged, and equipped; [~~(a)~~] toe grabs with a height greater than four millimeters worn on the front shoes of quarter horses and two millimeters worn on the front shoes of thoroughbred horses while racing are prohibited; the horse shall be scratched and the trainer may be subject to fine.

(21) ensuring that his/her horses are properly bandaged, and equipped; and no jockey, apprentice jockey, exercise person or any person mounted on a horse shall ride, breeze, exercise, gallop or workout a horse on the grounds of a facility under the jurisdiction of the commission unless the hose is equipped with a nylon rein or a safety rein; a safety rein is a rein with a wire or nylon cord stitched into the traditional leather rein during the manufacturing process and the safety cord is attached to the bit with a metal clasp;

(22) presenting his/her horse in the paddock at least 20 minutes before post time or at a time otherwise appointed before the race in which the horse is entered;

(23) personally attending to his/her horses in the paddock and supervising the saddling thereof, unless excused by the stewards;

(24) instructing the jockey to give his/her best effort during a race and that each horse shall be ridden to win;

(25) attending the collection of urine or blood sample from the horse in his/her charge or delegating a licensed employee or the owner of the horse to do so;

(26) notifying horse owners upon the revocation or suspension of his/her trainer's license; upon application by the owner, the stewards may approve the transfer of such horses to the care of another licensed trainer, and upon such approved transfer, such horses may be entered to race.

D. ASSISTANT TRAINERS.

(1) A trainer may employ an assistant trainer, who shall be equally responsible with the employing trainer for the condition of the horses in their care. The name of the assistant trainer shall be shown on the official program along with that of the employing trainer.

(2) Qualifications for obtaining an assistant trainer's license shall be prescribed by the stewards and the commission may include those requirements prescribed in Subsection A, Paragraph 1 of 16.47.1.10 NMAC.

(3) An assistant trainer shall assume the same duties and responsibilities as imposed on the licensed trainer.

(4) The trainer shall be jointly responsible for the assistant trainer's compliance with the rules governing racing.

E. SUBSTITUTE TRAINERS.

(1) If any licensed trainer is prevented from performing his duties or is absent from the track where he is participating, the stewards shall be immediately notified, and at the same time, a substitute trainer or assistant trainer, acceptable to the stewards, shall be appointed. The stewards shall be advised when the regular trainer resumes his duties.

(2) A substitute trainer must accept responsibility for the horses in writing and be approved by the stewards.

(3) A substitute trainer and the absent trainer shall be jointly responsible as absolute insurers of the condition of their horses entered in an official workout or race pursuant to Subsection B, Paragraphs (1), (2) and (3) of 16.47.1.10 NMAC.

[16.47.1.10 NMAC - Rp, 16 NMAC 47.1.10, 03/15/2001; A, 11/15/2001; A, 03/30/2007; A, 08/30/2007; A, 06/30/09]

NEW MEXICO REGULATION AND LICENSING DEPARTMENT

SECURITIES DIVISION

This is an amendment to 12.11.1 NMAC Section 11, effective 07/01/2009.

12.11.1.11 FEES: Note: The fees set forth in this [~~subpart~~] section do not include fees set by statute or as determined elsewhere in these rules; are expressly prescribed for the expenses of various matters arising pursuant to authority under the New Mexico Securities Act; are chargeable to the applicant, registrant or licensee; and, unless otherwise provided, are payable at the time an application or notice is filed. None of the fees paid are refundable.

A. Notice of exemption matters fees:

(1) A notice filed pursuant to Section 58-13B-27N(2) NMSA 1978 relating to offers to existing security holders shall be accompanied by a fee of $50.00.

(2) A notice filed pursuant to Section 58-13B-27Q NMSA 1978 relating to mergers shall be accompanied by a fee of $50.00.

(3) A notice filed pursuant to Section 58-13B-5C NMSA 1978 relating to federal covered advisers as set forth in 12.11.5.16 NMAC shall be accompanied by a fee of $300.00.

(4) A notice filed pursuant to Section 58-13B-24R NMSA 1978 relating to certain federal covered securities as set forth in 12.11.13.11 NMAC shall be accompanied by a fee of $50.00.

B. Administrative fees:

(1) The fee for processing a name change in registration statements on file is $50.00.

(2) The fee for processing a name change for a licensed broker-dealer or a licensed investment adviser is $50.00.

(3) The fee for an interpretative opinion, pursuant to Section 58-13B-51, or for a no action letter is $300.00.

C. Inspection fees: Licensees shall be charged a fee of one hundred dollars ($100.00) per examiner per day plus actual costs of transportation and lodging where applicable for examinations conducted pursuant to Section 58-13B-15 NMSA 1978.

D. Successor firms fees:

(1) An application for licensure of a successor firm pursuant to Section 58-13B-14A NMSA 1978 shall be accompanied by a fee of $300.00.

(2) An application for licensure of successor firms pursuant to Section 58-13B-14B NMSA 1978 shall be accompanied by an administrative fee of $35.00 for each representative's license which must be transferred to the successor firm.

E. Sales representative and investment adviser representative licensing fees. Pursuant to Section 58-13B-9A NMSA 1978 sales representatives and investment adviser representatives shall pay an annual licensing fee of [~~$40.00.~~] $50.00.

[12-30-95; 12.11.1.11 NMAC - Rn, 12 NMAC 11.1.2, 07-01-2003 & A, 07-01-2003; A, 07/01/2009]

NEW MEXICO STATE RECORDS CENTER AND ARCHIVES

This is an amendment to 1.13.2 NMAC, Sections 7 through 14 and 17 through 21, effective July 1, 2009.

1.13.2.7 DEFINITIONS:

A. "Acid-free" means having a pH of 7.0 or greater.

B. "Archival" means the material properties inherent in any medium permitting its preservation under controlled conditions.

C. "Certified copy" means a reproduction of a public record expressly verified by the custodial agency as a true and accurate representation of the official copy of the record.

D. "Clip" means a selected part of a motion picture film.

E. "Commercial-use requester" means a requester seeking records and information for a use or purpose that furthers the commercial, trade or profit interests of the requester, organization or person on whose behalf the request is made.

F. "Digital restoration" means digitally improving the overall appearance of a scanned photograph by adjusting brightness or contrast or both, sharpening, adjusting overall color, cropping, etc.

G. "DVD" means digital video disc, an optical disc storage medium.

[~~G.~~] **H.** "Enhancement" means digitally repairing a scanned photograph to remove signs of deterioration and damage (spots, tears, red eye, fold lines, etc.).

I. "JPEG" means a compressed image file format, commonly used for the compression of photographic images, developed by the joint photograph experts group.

J. "MiniDV" means a video digital storage format available in small cassettes with high storage capacity.

[~~H.~~] **K.** "Non-profit organization" means any organization, which by its articles of association and by-laws prohibits acts of private inurement, that is, transferring of the organization's earnings to persons in their private capacity; non-profit organizations are required to use their earnings for their program activities and these earnings are tax-exempt if the organization has met the approval of the internal revenue service as falling within a category such as 501(c) (3).

L. "Over-sized material" means maps, architectural drawings, books and textual and other documents larger than 12 inches by 16 inches.

[~~I.~~] M. "Record" means all books, papers, maps, photographs, recordings, tapes or other documentary materials, regardless of physical form or characteristics.

[~~J.~~] **N.** "Requester" means any individual who is not a commercial-use requester. This term does not include requests citing the Inspection of Public Records Act, which are handled in accordance with the law and agency policy.

[~~K.~~] **O.** "SRCA" means the state records center and archives.

P. "TIFF" means tagged image file format, a bitmap image format used for storing images.

[1.13.2.7 NMAC - N, 3/14/01; A, 7/15/03; A, 6/30/05; A, 6/1/06; A, 7/1/09]

1.13.2.8 PRICING: All fees cited in 1.13.2 NMAC are per item, unless otherwise specified.

[9/15/98; 1.13.2.8 NMAC - Rn, 1 NMAC 3.100.9.5 & A, 3/14/01; A, 7/1/09]

1.13.2.9 STORAGE BOXES [~~AND FORMS~~]:

[~~A. Boxes.~~]

[~~(1)~~] **A.** Microfilm box - $1.90

[~~(2)~~] **B.** Maps and drawings box - $2.10

[~~(3)~~] **C.** Cubic foot records storage box - $2.00

[~~B. Forms. Records storage transmittal form - $0.25~~]

[7/1/95, 1/1/98; 1.13.2.9 NMAC - Rn, 1 NMAC 3.100.8.1 & A, 3/14/01; A, 7/1/09]

1.13.2.10 ACID-FREE ARCHIVAL STORAGE CONTAINERS:

A. Document storage box 15 ¼ in. x 10 ¼ in. x 5 in. - [~~$3.30~~] $4.90

B. Document storage box 15 ¼ in. x 10 ¼ in. x 2 in - [~~$3.50~~] $4.85

C. Record storage box 15 in. x 12 in. x 10 in. - [~~$4.15~~] $5.40

D. Full telescope box 15 in. x 11 ½ in. x 3 in. - [~~$5.30~~] $12.05

E. Full telescope box 24 ½ in. x 20 ½ in. x 3 in. - [~~$6.90~~] $19.20

F. Clam shell box 15¼ in. x 10 ¼ in. x 3 ½ in. - [~~$3.45~~] $5.05

G. Newspaper box 25 in. x 19 in. x 2 ½ in. - [~~$7.50~~] $22.20

H. Legal size folder full tab package (100 count) - [~~$23.65~~] $34.40

I. Letter size folder full tab package (100 count) - [~~$21.00~~] $28.20

J. Corrugated board, 40 in. x 60 in. sheet - [~~$6.65~~] $12.01

K. Other containers - containers of sizes other than those listed above may be available at cost plus five percent.

[1.13.2.10 NMAC - N, 3/14/01; A, 4/30/02; A, 6/30/04; A, 6/1/06; A, 7/1/09]

[Please contact the Archives and Historical Services Division at 505-476-7956 for the availability and prices of the other containers noted in Subsection K.]

1.13.2.11 PHOTOCOPY FEES:

A. Paper photocopies.

(1) 8 ½ x 11 (1 to 99 copies) - $0.25

(2) 8 ½ x 11 (100 to 499 copies) - $0.40

(3) 8 ½ x 11 (500 or more copies) - $0.55

(4) 8 ½ x 14 (1 to 99 copies) - $0.30

(5) 8 ½ x 14 (100 to 499 copies) - $0.45

(6) 8 ½ x 14 (500 or more copies) - $0.60

(7) 11 x 17 (1 to 99 copies) - $0.35

(8) 11 x 17 (100 to 499 copies) - $0.50

(9) 11 x 17 (500 or more copies) - $0.65

[~~**B.** Certified paper photocopies.~~

~~**(1)** 8 ½ x 11 (1 to 99 copies) - $0.50~~

~~**(2)** 8 ½ x 11 (100 to 499 copies) - $0.80~~

~~**(3)** 8 ½ x 11 (500 or more copies) - $1.00~~

~~**(4)** 8 ½ x 14 (1 to 99 copies) - $0.60~~

~~**(5)** 8 ½ x 14 (100 to 499 copies) - $0.90~~

~~**(6)** 8 ½ x 11 (500 or more copies) - $1.00~~

~~**(7)** 11 x 17 (1 to 99 copies) - $0.70~~

~~**(8)** 11 x 17 (100 or more copies) - $1.00~~]

B. Certification of paper copies - $0.50 per page.

C. Self-service photocopies (made by patron).

(1) 8 ½ x 11 - $0.10

(2) 8 ½ x 14 - $0.10

(3) 11 x 17 - $0.15

D. Oversized [~~maps and drawings~~] records (color or black and white)

(1) 12 x 18 - [~~$3.35~~] $8.00

(2) 17 x 22 - [~~$3.40~~] $8.00

(3) 18 x 24 - [~~$3.35~~] $8.00

(4) 22 x 34 - [~~$3.40~~] $8.00

(5) 24 x 36 - [~~$3.45~~] $12.00

(6) 30 x 42 - [~~$3.50~~] $12.00

(7) 32 x 44 - [~~$3.90~~] $12.00

(8) [~~36 x 48 - $4.10~~] 35.5 x 48 - $16.00

(9) [~~Sizes greater than 36 x 48 add $1.00 per foot to $4.10~~] Sizes greater than 35.5 x 48 add $4.00 per each additional foot. Width cannot exceed 35.5 inches.

E. Fax copies - $0.60

[7/1/95, 1/1/98, 9/15/98; 1.13.2.11 NMAC - Rn, 1 NMAC 3.100.9.1 through 1 NMAC 3.100.9.4 and 1 NMAC 3.100.13 & A, 3/14/01; A, 6/30/04; A, 7/1/09]

1.13.2.12 MICROPHOTOGRAPHY FEES:

A. Microfilm to paper copies (made by staff).

(1) 8 ½ x 11 - $0.50

(2) 8 ½ x 14 - $0.60

B. Self-service microfilm to paper copies.

(1) 8 ½ x 11 - $0.10

(2) 8 ½ x 14 - $0.10

(3) 11 x 14 - $0.15

C. Microfilm duplication.

(1) 16mm - $12.00 per reel

(2) 35mm - $16.00 per reel

[~~**D.** Compact disk duplication services archival collections.~~

~~**(1)** Land records of New Mexico (Spanish archives of New Mexico I - SANM I) - $1,250.00~~

~~**(2)** Spanish archives of New Mexico II (SANM II) - $250.00~~

~~**(3)** Translations - $125.00~~

~~**(4)**Mexican archives of New Mexico (MANM) - $725.00~~

~~**(5)** Territorial archives of New Mexico (TANM) - $7,340.00~~

~~**(6)** Sender Collection - $50.00~~

~~**E.**~~] **D.** Microfilm services.

(1) Technical consultation and assistance - $10.00 per hour with a minimum charge of one hour

(2) Document preparation - $10.00 per hour with a minimum charge of one hour, plus cost of supplies

(3) Microfilming - $0.35 per image

(4) Microfilm processing, 16 mm and 35 mm - $19.85 per reel

(5) Step-test analysis - $5.00 per analysis

E. Microfilm to electronic media (made by staff) - $0.70 per image on CD.

F. Self-service microfilm to electronic media - $0.30 per image on CD.

[7/1/95, 9/15/98, 12/15/98; 1.13.2.12 NMAC - Rn, 1 NMAC 3.100.10 & A, 3/14/01; A, 4/30/02; A, 6/30/04; A, 6/30/05; A, 7/1/09]

1.13.2.13 [~~PHOTOGRAPH, MOTION PICTURE AND OVERSIZED RECORDS REPRODUCTION:~~] DIGITAL REPRODUCTION OF PHOTOGRAPHS, OVERSIZED RECORDS AND MOVING IMAGE MATERIAL:

A. Requests for duplication and reproduction of [~~photographs and film~~] public records that are covered under Section 14-3-15.1 NMSA 1978 or are copyrighted or otherwise contractually restricted shall be accompanied by a letter of intent describing the proposed use and SRCA form 96-18 "conditions for publication/reproduction."

[~~**B.** Prints from digital images.~~

~~**(1)** 5 x 7 - $14.00~~

~~**(2)** 8 x 10 - $14.00~~

~~**(3)** Larger than 8 x 10 - $7.75 per foot~~

~~**C.** Video copies.~~

~~**(1)** VHS video cassette to VHS video cassette copies - $30.00~~

~~**(2)** Motion picture film to VHS video cassette copies - $47.50~~

~~**D.** Digital copies.~~

~~**(1)** Motion picture film to DVD copies - $55.00~~

~~**(2)** Motion picture film to miniDV or DV copies - $58.00~~

~~**(3)** Video cassette to DVD copies - $37.00~~

~~**(4)** Video cassette to miniDV or DV copies - $40.00~~

~~**(5)** MiniDV to miniDV or DV copies - $40.00.~~]

B. Photographs. Prices are assessed per individual image.

(1) 8 x 10 print from digital images file - $17.00. This option is not available for oversized material. See 1.13.2.11 NMAC, *photocopy fees*.

(2) 8 x 10 print from original source material - $21.00. This option is not available for oversized material. See 1.13.2.11 NMAC, *photocopy fees*.

(3) Reproduction of digital image files (JPEG or TIFF) - $14.00

(4) Creation of digital image file (JPEG or TIFF) from original source material - $19.00

(5) Digital image file (JPEG) from digital image file delivered via e-mail - $14.00. Digital image files shall be limited to 8 x 10 images scanned at 300 dots per

inch (dpi).

(6) Digital image file (JPEG) from original source material delivered via e-mail - $19.00. Digital image files shall be limited to 8 x 10 images scanned at 300 dpi.

C. Moving image material. Prices are assessed per moving image title.

(1) VHS video cassette from digital video file or miniDV master - $17.00

(2) VHS video cassette from original source material - $50.00

(3) MiniDV tape from digital video file or miniDV master - $20.00

(4) MiniDV tape from original source material - $52.00

(5) DVD from digital video file of miniDV master - $15.00

(6) DVD from original source material - $47.00

[~~**E.**~~] **D.** Where items are fragile or require specialized handling, the SRCA may charge the costs of the additional labor.

[~~**F.**~~] **E.** Fees for digital restoration or enhancement or clip selection of digitized materials or motion picture films vary according to the extent of work required. The minimum fee for digital restoration or enhancement or clip selection shall be $15.00 per reproduced item, in addition to the reproduction fee set forth in Subsection B of this section. For work requiring over one hour, $15.00 per additional hour shall be charged.

F. Expedited orders can be requested for an additional fee of $20.00. Waiting time will be reduced by one week.

[7/1/95, 4/30/96, 12/15/98; 1.13.2.13 NMAC - Rn, 1 NMAC 3.100.11 & A, 3/14/01; A, 4/30/02; A, 7/15/03; A, 6/30/05; A, 6/1/06; A, 06/30/07; A, 7/1/09]

1.13.2.14 SRCA PUBLICATIONS:

A. Calendar to the Spanish archives of New Mexico II - $10.00

B. Calendar to the Mexican archives of New Mexico - $6.00

C. Calendar to the territorial archives of New Mexico - $6.00

D. Calendar to land records of New Mexico (Spanish archives of New Mexico I) - $10.00

E. Calendar to the Sender collection - $12.00

F. Guide to "lost" records of Zuni - $7.00

G. Microfilm manual - $18.50

H. Genealogy charts - [~~$3.50~~] $8.00

I. New Mexico administrative code training manual - extra copies (individuals attending training receive one copy of the manual without charge) - $22.50

J. Billy the Kid packet - [~~$37.80~~] $49.00

K. Guide to the archdiocese of Santa Fe: the AASF and LDS series - $7.00

L. New Mexico county marriage register inventory - $7.00

[~~**M.** Picture postcards - $5.00~~]

[7/1/95, 9/15/98, 12/15/98; 1.13.2.14 NMAC - Rn, 1 NMAC 3.100.12 & A, 3/14/01; A, 4/30/02; A, 7/15/03; A, 6/30/04; A, 7/1/09]

1.13.2.17 ELECTRONIC COPIES OF RECORDS: [~~Electronic copies of records - $0.0005 per byte, in full or in part.~~]

A. Portable document format file (PDF) from microsoft word or PDF file.

(1) 1 to 99 pages - $0.25 per page

(2) 100 to 499 copies - $0.40 per page

(3) 500 or more copies - $55 per page

B. PDF from digital image file.

(1) 1 to 99 pages - $1.75 per page

(2) 100 to 499 copies - $2.00 per page

(3) 500 or more copies - $2.25 per page

C. PDF from original source.

(1) 1 to 99 pages - $3.25 per page

(2) 100 to 499 copies - $3.50 per page

(3) 500 or more copies - $3.75 per page

[1.13.2.17 NMAC - N, 04/30/02; A, 7/1/09]

1.13.2.18 CHARGES FOR PUBLISHING IN THE NEW MEXICO REGISTER: There shall be a [~~$1.50~~] $2.00 per column inch charge to agencies publishing material in the New Mexico register.

[1.13.2.18 NMAC - N, 7/15/03; A, 7/1/09]

[Charges for publishing in the New Mexico register are also found in 1.24.15.12 NMAC.]

1.13.2.19 COPIES OF THE NEW MEXICO REGISTER:

A. Individual copies of the New Mexico register - $12.00.

B. Annual paper subscription fees for the New Mexico register - $270.00.

[~~**C.** Advertising rates for New Mexico register:~~

~~**(1)** single, full page insertion - $150.00;~~

~~**(2)** single, half page insertion - $80.00; and~~

~~**(3)** single, quarter page insertion - $50.00.~~

~~**D.** Electronic copies of the New Mexico register - as set forth in 1.13.2.17 NMAC.~~]

[1.13.2.19 NMAC - N, 7/15/03; A, 7/1/09]

[Fees for copies of the New Mexico register are also found in 1.24.15.13 NMAC.]

1.13.2.20 RECORDS STORAGE SERVICES:

A. State agency records, paper.

(1) Records that have not met their legal retention or that have been subpoenaed or are otherwise involved in ongoing litigation or an active investigation - no charge

(2) Records that have met their legal retention and for which the SRCA has issued a [~~destruction~~] disposition notice - [~~$0.25~~] $0.50 per month per box (see 1.13.10 NMAC)

B. Municipal and county records, paper - [~~$0.25~~] $0.50 per box (either cubic-foot or maps and drawings box) per box, regardless of whether retention has been met (see 1.13.2 NMAC).

C. State agency records, microfilm.

(1) Records that have not met their legal retention or that have been subpoenaed or are otherwise involved in ongoing litigation or an active investigation - no charge

(2) Records that have met their legal retention and for which the SRCA has issued a [~~destruction~~] disposition notice - [~~$0.04~~] $0.25 per 16mm roll equivalent per month (see 1.13.10 NMAC)

D. Inactive municipal and county records, microfilm - [~~$0.04~~] $0.25 per 16mm roll equivalent per month, regardless of whether retention has been met (see 1.13.10 NMAC).

[1.13.2.20 NMAC - N, 6/30/05; A, 7/1/09]

[The SRCA is not, as of the effective date of this section, imposing fees for the storage of electronic records.]

1.13.2.21 COMMERCIAL-USE FEES:

A. Commercial-use requesters, as defined in 1.13.2 NMAC, who make requests for records shall be assessed a commercial service fee. Service fees shall be pre-paid and shall be in addition to the fees for copying or reproduction prescribed in 1.13.2 NMAC.

B. The SRCA requires all requesters to submit a letter of intent and SRCA form 96-18, "conditions for publication/reproduction," before a request is considered.

C. Not-for-profit organizations requesting reproductions of records and information for fund raising shall be

charged 50 percent of the applicable commercial-use fees. Proof of not-for-profit status shall be provided before the not-for-profit rate is considered.

D. The SRCA reserves the right to require proof of intent of publication prior to final approval.

E. The SRCA shall not grant exclusive rights for use of its materials. Permission shall be granted for one time use only. Requesters shall submit an additional letter of intent and SRCA form 96-18 "conditions for publication/reproduction" and pay additional fees for any subsequent use.

F. The SRCA reserves the right to restrict the use of reproductions of rare and valuable records and to make special fee quotations on records involving unusual and difficult reproduction.

G. Fees for commercial use of reproductions of records in books, including book jackets and end papers, shall be as follow:

(1) less than 5,000 editions - $30.00 per reproduction;

(2) 5,000 to 24,999 editions - $75.00 per reproduction;

(3) 25,000 or more editions - $100.00 per reproduction.

H. Fees for commercial use of reproductions of records in serials, magazines, including magazine covers, and newspapers shall be as follow:

(1) circulation of 49,999 or less - $20.00 per reproduction;

(2) circulation 50,000 to 99,999 - $50.00 per reproduction;

(3) circulation over 100,000 - $100.00 per reproduction.

I. Commercial use of reproductions of records in videotapes, CD-ROMs, DVDs or other digital media shall require a fee of $150.00 per reproduction.

J. Commercial use of reproductions of records in motion picture productions and documentaries shall require a fee of $150.00 per reproduction.

K. Fees for commercial use of reproductions of records for posters, postcards, T-shirts, calendars, mousepads and non-paper shall be as follow:

(1) less than 999 items - $20.00 per reproduction;

(2) 1,000 to 4,999 items - $75.00 per reproduction;

(3) 5,000 or more items - $100.00 per reproduction.

L. Fees for commercial use of reproductions of records in advertising shall be as follow:

(1) display in commercial offices, stores, and restaurants - $25.00 per reproduction;

(2) other advertising formats - $150.00 per reproduction.

M. Fees for commercial use of reproductions of records in exhibits shall be $30.00 per image in exhibit. Fees for not-for-profit organizations will be waived if admission to the exhibit is free.

[1.13.2.21 NMAC - N, 6/1/06; A, 7/1/09]

[See 1.13.2.15 NMAC for a description of form 96-18.]

NEW MEXICO STATE RECORDS CENTER AND ARCHIVES

This is an amendment to 1.13.7 NMAC, Sections 7, 11 and 13 effective 07/01/09

1.13.7.7 DEFINITIONS:

A. Fellowship means a [~~stipend awarded by the office of the state historian, a division of the state records center and archives, to conduct research~~] contract with the state records center and archives, under the terms of which the contractor (fellow) receives compensation for research and other deliverables as defined in the contract and pursuant to the provisions of 1.13.7 NMAC.

B. Research means, for purposes of 1.13.7 NMAC, research conducted using primary sources from New Mexico archival repositories containing material relative to the history and cultures of New Mexico.

C. Independent scholar means an individual, regardless of academic credentials, who is recognized as an authority in any field or discipline that advances an understanding and appreciation of New Mexico history. Independent scholars may include individuals such as community historians, tribal elders, etc.

D. Archival repository means an archival repository in New Mexico that contains material relative to the history and cultures of New Mexico.

[1.13.7.7 NMAC - N, 06/30/05; A, 06/01/06; A, 05/15/07; A, 07/01/09]

1.13.7.11 FUNDING AND COMPENSATION:

A. The New Mexico office of the state historian scholars program is contingent on sufficient appropriation and operating budget.

B. Although an applicant shall request, pursuant to 1.13.7.10 NMAC, a fellowship for a given amount, duration and time, the decisions concerning these issues shall be made by the fellowship awards committee and shall be based on funding availability, the nature of the proposed research and access to collections and the number of fellowships awarded. All research and all post-award requirements conducted under a fellowship shall be completed by the end date of the fellowship period and, in all cases, no later than June 30 of the fiscal year in which the fellowship is awarded.

C. A successful applicant shall enter into [~~an acceptance agreement~~] a contract issued by the state records center and archives, which shall describe the specific research topic, research requirements, specific deliverables, timetables and compensation provisions.

D. As set forth in 1.13.7.8 NMAC, compensation shall not exceed $1000 per month. For a fellowship of one-month duration, payment shall be made at the conclusion of the fellowship, subject to the successful completion of all fellowship requirements. For a fellowship of duration of longer than one month, payment shall be made monthly, subject to the successful completion of identified deliverables. The deliverables shall be delineated in the acceptance agreement.

[1.13.7.11 NMAC - N, 06/30/05; A/E, 04/14/06; A, 06/01/06; A, 07/01/09]

1.13.7.13 POST-AWARD REQUIREMENTS: Successful fellowship applicants shall comply with the following post-award requirements.

A. Research work shall take place at New Mexico archival repositories containing material relative to the history and cultures of New Mexico.

B. Prior to the conclusion of the fellowship period, each fellow shall be required to give a public lecture based on the research accomplished during the fellowship period.

C. Each fellow shall be required to submit a report of research findings [~~within one week of completing a fellowship~~] prior to the conclusion of the fellowship. Each fellow shall produce and submit a three-page or longer, historical essay that may be included in the New Mexico history web project. In addition, the fellow shall submit any completed research findings that result in reports, papers, chapters and manuscripts to the state records center and archives. All submitted material shall be included in the state archives unpublished manuscript collection and shall be accessible to the public. Failure to comply with this requirement shall require immediate reimbursement to the state of the fellowship award. These requirements shall be further defined in the acceptance agreement.

[1.13.7.13 NMAC - N, 06/30/05; A, 06/01/06; 05/15/07; A, 07/01/09]

NEW MEXICO STATE RECORDS CENTER AND ARCHIVES

This is an amendment to 1.13.10 NMAC, Sections 10, 11, 14, 15, 16 and 18, effective June 30, 2009.

1.13.10.10 TRANSFER AND PICK-UP:

A. Only inactive records shall be accepted for transfer and storage at the records center. Records are considered inactive when an agency refers to an individual box less than once a year.

B. Inactive records involved in litigation, an audit or investigation are not eligible for transfer to the archives and historical services division.

[~~B.~~] **C.** The records center requires the use of records storage boxes, 15" x 12" x 10" in size for both letter and legal size paper files. An agency submitting boxes for storage containing paper records shall:

(1) place only one type of record series with the same disposition date in each box;

(2) place the records in the box vertically and in the same order that they were kept in the office;

(3) place letter-sized folders across the 12-inch side, facing the front of the box;

(4) place legal-sized folders across the 15 inch side, starting from left to right;

(5) leave at least one inch of space for ease of access;

(6) place the lid on the box without tape;

(7) place all documents (with the exception of oversize materials) in accurately labeled standard file folders; and

(8) not place hanging file folders in the boxes.

[~~C.~~] **D.** Boxes that are damaged or overfilled shall be rejected for storage and returned to the custodial agency.

[~~D.~~] **E.** Blueprints and maps submitted for storage shall be placed in boxes designed for that purpose before they are transferred.

[~~E.~~] **F.** A records custodian or a records liaison officer may designate personnel to pick up agency records from the records center.

[~~F.~~] **G.** Pick-up personnel shall be appointed annually, using a form approved by the state records administrator. The form shall include but not be limited to the following: name and signature of the records custodian (agency head or cabinet secretary); name and signature of the records liaison officer; pick-up personnel's name and signature; section/unit; agency code; agency name and mailing address; fiscal year of designation; phone number; fax number and e-mail address.

[~~G.~~] **H.** If a pick-up only designee leaves the employment of an agency or is released from the duty of picking up records, the agency shall immediately notify the state records center and archives (agency analysis bureau) regarding the change.

[1.13.10.10 NMAC - Rp, 1 NMAC 3.2.10.1.11, 6/30/2005; A, 6/30/2008; A, 6/30/2009]

1.13.10.11 ACCESS TO AND WITHDRAWAL OF RECORDS IN CUSTODY OF THE CUSTODIAL AGENCY:

A. Access to records stored in the records center shall be authorized in writing by the records custodian or the designated records liaison officer. The authorization shall be submitted to the records center and must specify the name of the individual(s) authorized to access the records and the effective period of the authorization.

B. Requests by the public to access records stored at the state records center shall be directed to the records custodian or the records liaison officer of the custodial agency.

C. Requests to review records on-site at the records center by the custodial agency shall be authorized by the records custodian or the records liaison officer. Personal identification must be provided to the records center staff.

D. Requests to access agency records made under the Inspection of Public Records Act shall be referred by the state records administrator to the custodial agency.

E. Requests for temporary or permanent withdrawal of records stored in the records center shall be made by the records liaison officer. The records liaison officer shall complete and submit a withdrawal form. The form shall include but not limited to the following; name and signature of the records liaison officer; date and time of transaction; agency name; agency address; records liaison officer's phone number; date requested; destination; box number; shipment box number; barcode; location; record series item number; description; and return date.

F. Requests for withdrawals shall be at the box level. The records center will not honor requests for withdrawal of records at the folder level.

G. When permanent records or those eligible for transfer to archives are temporarily withdrawn, the custodial agency shall update the corresponding index to reflect any changes to the content of a box. The index shall be updated before the box is returned to the records center for storage.

[~~G.~~] **H.** Requests to withdraw between one to 10 boxes shall be processed by the records center within 24 hours. Requests to withdraw 10 or more boxes shall be evaluated by the records center bureau chief and processed based on the work load of the record center staff.

[1.13.10.11 NMAC - Rp, 1 NMAC 3.2.10.1.12, 6/30/2005; A, 6/30/2008; A, 6/30/2009]

1.13.10.14 STORAGE OF PERMANENT PAPER RECORDS:

A. Records with the disposition of transfer to archives, which include records with the retention of permanent or transfer to archives, shall include an index approved by the state records center and archives that describes the contents of the box. The index shall include the following: [~~name of agency; date of shipment; permanent box number; shipment box number; schedule item number; record series title; the beginning and ending dates of the record series; confidentiality note if any; and records liaison officer or the records custodian name.~~] agency code, agency name, division name, shipment date, shipment box number (e.g., 1 of 10, 2 of 10, 3 of 10, etc.), folder number, records series number, records series title, confidential note if any, folder description and date of material.

B. A copy of the index shall be placed in the storage box. [~~and a second copy shall be submitted with the corresponding storage transmittal form or request for disposition form.~~] A second copy of the index shall be submitted with the corresponding storage transmittal forms.

C. The storage transmittal form and the request for disposition form shall have an attached index before the boxes are approved for storage or transfer. All file folders in the box shall be clearly labeled and identify the contents of the folder.

D. The records custodian and the records liaison officer [~~will~~] shall be notified by the records center when records are eligible for transfer to the state archives.

[1.13.10.14 NMAC - N, 6/30/2005; A, 6/30/2009]

1.13.10.15 STORAGE OF ELECTRONIC [~~RECORDS~~] MEDIA:

A. An agency shall have an approved imaging plan on file with the state records center and archives (electronic records and micrographic bureau) before electronic media can be stored. For information on imaging plans see 1.14.2.16 NMAC, Microphotography Systems, Microphotography Standards.

[~~A.~~] **B.** An agency shall complete a storage transmittal form and submit it to the state records center and archives (agency analysis bureau) for approval. An agency records liaison officer may contact the state records center and archives (records management division) for information and assistance with storage.

(1) The storage transmittal form shall be signed by the agency's records custodian or records liaison officer.

(2) At a minimum, each individual unit (tape, disk, etc.) of electronic media shall be clearly identified with the agency name, record series and disposition date.

[~~B.~~] C. Agencies that elect to have record liaison officers submit storage transmittal forms electronically, shall submit a written request to the state records center and archives (agency analysis) bureau chief requesting access to the electronic tracking system. The request shall contain but is not limited to the following: agency name, division name, bureau name, record liaison officer's name and contact information. If access is granted the agency analysis bureau shall notify the agency in writing of the password and ID assigned to the record liaison officer.

[~~C.~~] **D.** Withdrawal and access to electronic retention files shall be through the standard records center procedure for access and withdrawal of records. For information on record withdrawal procedures see 1.13.10.11 NMAC.

[~~D.~~] **E.** Agencies are responsible for safeguarding against storage media deterioration and technology changes that can leave electronic records inaccessible over a period of time because of hardware or software obsolescence. To eliminate the possibility of creating a situation where information can no longer be retrieved, agencies shall provide for future record accessibility by:

(1) migrating all electronic records when there are major changes to the next generation of hardware or software; or

(2) migrating only current electronic records to new hardware or software, and converting records not migrated to "human readable form"; for additional information, see 1.13.3 NMAC, Management of Electronic Records.

[~~E.~~] **F.** The records custodian and records liaison officer shall be notified by the records center when records in storage have met the legal retention period and are eligible to be transferred to archives or are eligible for destruction.

[1.13.10.15 NMAC - N, 6/30/2005; A, 6/29/2007; A, 6/30/2009]

1.13.10.16 STORAGE OF MICROFILM:

A. An agency shall have an approved microphotography plan on file with the state records center and archives (electronic records and micrographic bureau) before master microfilm can be stored. For information on microphotography systems and standards see 1.14.2 NMAC.

B. The microphotography plan shall specify that the master microfilm will be stored at the state records center and archives (electronic records and micrographics bureau).

C. Agency's records liaison officers or microfilm vendors approved by an agency to transfer microfilm to the state records center shall complete a microfilm storage transmittal form and submit it manually (hardcopy) to the agency analysis bureau for approval before records can be stored. The form shall contain but is not limited to the following: agency code; agency name; division name; date prepared; page number; office location; name and signature of the records liaison officer; records liaison officer telephone number; records liaison officer fax number; record series number; record series title; date filmed; begin date; end date; disposition date; roll number; begin document; end document and media type.

D. Microfilm rolls or microfiche with a retention period of permanent or transfer to archives submitted for storage to the electronic records and micrographics bureau shall include an index as described in Subsection A of 1.13.10.14 NMAC. An index shall be provided for each individual roll or microfiche card.

[~~D.~~] **E.** Microfilm shall pass inspection before it is approved for storage. Information on microfilm that has passed inspection will be entered into a computer tracking system by the electronic records and micrographics bureau staff. The computer system assigns permanent container numbers.

[~~E.~~] **F.** Microfilm storage transmittal forms shall be returned to the custodial agency with a notation indicating the assigned permanent container numbers.

[~~F.~~] **G.** It is the responsibility of the custodial agency to notify the microfilm vendor under contract that the microfilm has passed inspection.

[~~G.~~] **H.** After the microfilm has passed inspection and has been approved for storage the custodial agency shall submit a *request for disposition* form to the state records center and archives (agency analysis bureau) requesting authorization to dispose of the source documents.

[~~H.~~] **I.** If the microfilm has failed inspection, the electronic records and micrographics bureau staff shall notify the agency by letter that the microfilm can not be stored and that source documents shall be re-filmed before they can be destroyed.

[~~I.~~] **J.** For the procedure on withdrawal and access of records stored at the electronic records and micrographics bureau, see 1.13.10.11 NMAC.

[~~J.~~] **K.** The records custodian and records liaison officer shall be notified by the records center when records in storage have met the legal retention period and are eligible to be transferred to archives or are eligible for destruction.

[~~K.~~] **L.** If an agency does not respond to the records center's *notice of records eligible for destruction* by the established deadline, the state records center and archives [~~will~~] shall charge the custodial agency a storage fee as established in 1.13.2 NMAC, Fees.

[1.13.10.16 NMAC - N, 6/30/2005; A, 6/30/2008; A, 6/30/2009]

1.13.10.18 DIRECT TRANSFER OF RECORDS TO THE ARCHIVES AND HISTORICAL SERVICES DIVISION: [~~An agency may transfer records with permanent retention period to the archives division directly by submitting a request for disposition form to the agency analysis bureau for approval. The request for disposition form shall list only those records that are eligible for transfer to the archives division. The archives division will notify the agency when to deliver the records to the state records center and archives. Once the records are transferred to and accessioned by the archives division, legal title and custody of the records is also transferred from the creating agency to the state records center and archives.~~]

A. An agency may transfer records with a retention period of permanent or transfer to archives to the archives and historical services division directly by submitting a request for disposition form and the required index to the agency analysis bureau for review and approval. The request for disposition form shall list only those records that are eligible for transfer to the archives and historical services division.

B. For direct transfers to the archives and historical services division an index shall be created in microsoft excel format. See Subsection A of 1.13.10.14 NMAC for a description of the required content of the index. Prior to delivery of the records the agency shall provide the accessioning archivist with an electronic copy of the index in microsoft excel format by e-mail or on CD-ROM. The accessioning archivist will notify the agency when to deliver the records to the state records center and archives.

C. Inactive records involved in litigation, an audit or investigation are not eligible for transfer to the archives and historical services division.

D. Once authorization is received for the transfer of records to the archives and historical services division

from the records custodian and the state records administrator accepts the records, the legal title and custody of the records is also transferred from the creating agency to the state records center and archives.
[1.13.10.18 NMAC - N, 6/29/2007; A, 6/30/2009]

NEW MEXICO STATE RECORDS CENTER AND ARCHIVES

This is an amendment to 1.13.11 NMAC, Sections 8 and 9, effective June 30, 2009.

1.13.11.8 GUIDELINES FOR USE OF ARCHIVES RESEARCH ROOM:

A. Research room hours are [~~8:00~~] 10:00 am to 4:45 pm, Monday through Friday, except holidays or other times specified by NMSRCA.

(1) Reference assistance is available from [~~9:00~~] 10:00 am to 12:00 pm and 1:00 pm to 4:30 pm.

(2) Historical films and videos can be viewed by appointment only.

(3) Requests to view 10 or more photographs require an appointment.

(4) Material shall not be pulled from the vault between 12:00 pm and 1:00 pm or after 4:15 pm.

B. All researchers and visitors [~~must~~] shall sign the daily log as they enter the research rooms.

C. Researchers [~~must~~] shall complete a [~~one-time~~] user registration form (SRC 96-20).

(1) Researchers shall be asked to update registration forms periodically.

(2) To register, researchers shall provide photographic identification. Acceptable forms of identification include a driver's license, a school or business identification card, or a passport.

D. The NMSRCA prohibits researchers from carrying boxes, briefcases, satchels, valises, backpacks, purses, folders, coats, newspapers, or other large containers into the research rooms.

(1) Researchers will be provided lockers for their belongings on a first-come, first-serve basis. Lockers are available for a quarter.

(2) Researchers' personal belongings must be removed from the lockers each night.

E. Except as provided in Paragraphs (1) through (4) of Subsection E of 1.13.11.8 NMAC, only paper and pencils may be taken into the research rooms.

(1) Researchers may use a personal computer [~~or tape recorder~~] provided their use does not disturb others. The speakers shall be disabled or lowered to an inaudible level.

(2) Cell phones brought into the research rooms are subject to the following procedures.

(a) Cell phones must be placed on vibrate mode.

(b) Calls must be made or answered outside of the research rooms.

[~~(3) Tape recorders; cameras and other video equipment may be brought into the research rooms. Equipment is subject to the following procedures:~~

~~(a) A written request shall be submitted to director for approval.~~

~~(b) Approval shall be granted before equipment is allowed to be brought into the research rooms.~~

~~(c) If approval is not granted, requester will be notified with explanation.~~

~~(d) Equipment is subject to inspection by staff prior to admittance.~~]

(3) Researchers may use still digital or film cameras in the research rooms provided their use does not disturb others and subject to the following procedures.

(a) Researchers shall request approval from the archivist on duty before the equipment is allowed into the research rooms.

(b) Equipment is subject to inspection by staff prior to admittance.

(c) Flash photography is not allowed in any research room. Violators will be asked to put their cameras away.

(d) Researchers shall place a "New Mexico state records center and archives" template on each page photographed. Staff will supply the template. Template shall be returned to staff once work is completed.

(e) Researchers shall follow the copyright law of the United States (Title 17, United States Code) which governs the making of photocopies or other reproductions of copyrighted material. If publishing materials, researchers shall comply with the commercial use fees pursuant 1.13.2.21 NMAC and with 1.13.2.10 NMAC.

(4) Notes, references, list of documents to be consulted, such as one spiral notebook or binder, may be admitted if they are essential to a researchers work but are subject to inspection upon entering or leaving the research rooms.

(5) Researchers may use approved optical scanners in the research rooms provided their use does not disturb others and subject to the following procedures.

(a) Researchers shall request approval from the archivist on duty before the equipment is allowed into the research room.

(b) Equipment is subject to inspection by staff prior to admittance.

(c) Prior to scanning, researchers shall present the material to be scanned to the archivist on duty for approval. The archivist shall refuse a request if he or she determines that scanning would damage the materials.

(d) If approved for scanning, researchers shall follow scanning guidelines. Guidelines will be provided by the archivist on duty.

(e) Researchers shall follow the copyright law of the United States (Title 17, United States Code) which governs the making of photocopies or other reproductions of copyrighted material. If publishing materials, researchers shall comply with the commercial use fees pursuant 1.13.2.21 NMAC and with 1.13.11.10 NMAC.

F. No eating, drinking, or smoking is permitted in the research rooms.

G. Loud talking or other activities likely to disturb other researchers is prohibited.

H. Children under the age of 16 years shall not be admitted in the research rooms unless they are accompanied by an adult. The [~~director of archives and historical services~~] archivist on duty may waive this requirement with respect to individual researchers.

I. Researchers refusing to comply with NMSRCA research room guidelines or whose actions present a danger to the documents or annoyance to other researchers shall be denied access to archival collections and shall be asked to leave by the director of archives and historical services.
[07/01/96; 1.13.11.8 NMAC - Rn, 1 NMAC 3.2.10.2.8 & A, 07/15/03; A, 06/01/06; A, 06/30/09]

1.13.11.9 GUIDELINES FOR USE OF DOCUMENTS:

A. Researchers shall complete a records request form (SRC Form 11A) when requesting documents.

(1) The name of the collection, series, box, and folder number shall be noted.

(2) The researcher shall hand the completed request form to an archivist or the person at the reference desk.

B. Researchers shall use documents only in research rooms. Documents shall not be removed from the research room.

C. Original records shall not normally be made available when microfilm or digital copies are available.

D. Archivists may limit the quantity of materials delivered to a researcher at one time.

(1) Only one folder, box, or container of documents may be made available to a researcher at one time.

(2) The researcher may exchange

one container (box) for another by informing an archivist or the person at the reference desk.

E. The researcher is responsible for all records delivered to him until he returns them.

(1) Before leaving the research room, even for a short time, the researcher shall notify the person at the reference desk and place all documents in their proper container.

(2) When the researcher is finished using the records, they shall be returned to the reference desk.

(3) Researchers shall return all materials to the archivist on duty by 4:30 pm. No exceptions shall be made.

F. Researchers shall keep unbound records in the order in which they are delivered to him.

(1) Documents that appear to be in disorder shall not be rearranged by the researcher, but shall be referred to an archivist.

(2) Researchers shall not remove documents from more than one folder at a time.

G. Researchers shall not write on, lean on, fold, trace, erase, staple, or handle documents in any way likely to damage them.

H. The use of protective gloves shall be required with the use of documents.

I. Use of microfilm readers at the NMSRCA is on a first-come, first-serve basis. When other researchers are waiting to use a microfilm reader, a 3-hour limit may be placed on using a reader. During periods of heavy use, researchers may sign a waiting list for the use of a microfilm reader.

J. Microfilm is available on a self-service basis.

(1) Archivists may assist researchers in identifying rolls of film.

(2) After using each roll, the researcher shall rewind the film and place the roll in the re-file basket.

(3) Researchers shall bring to the attention of an archivist microfilm placed in the wrong box or file cabinet.

(4) Researchers shall bring to the attention of an archivist microfilm that is backwards on the reel.

K. Reference books may be taken off the shelf by researchers.

(1) Books shall not be re-shelved by researchers.

(2) Books shall only be used in the research room.

L. Fragile, oversized, and certain rare books shall not be photocopied.

[07/01/96; 1.13.11.9 NMAC - Rn, 1 NMAC 3.2.10.2.9 & A, 07/15/03; A, 06/01/06; A, 06/30/09]

NEW MEXICO STATE RECORDS CENTER AND ARCHIVES

This is an amendment to 1.14.2 NMAC, Sections 6, 7, 9, 10, 12, 14 and 17, effective June 30, 2009.

1.14.2.6 OBJECTIVE: [~~To ensure uniformity and legal acceptability, and to facilitate the microphotography of public records of government entities, the following standards, targets, and image sequence and spacing shall be adopted for source document microphotography.~~] To establish methods for prescribing the capture, quality and permanence of microfilm and digital images produced by microphotography systems to: ensure that in their content and detail the microfilm and digital images represent accurate reproductions of the original records; that they serve the purposes for which the original records were created; and that they meet the legal acceptance requirements of records produced by information technology systems. See 1.13.70 NMAC, Performance Guidelines For the Legal Acceptance of Public Records Produced by Information Technology Systems.

[6-8-74...7-29-96; 1.14.2.6 NMAC - Rn, 1 NMAC 3.2.60.1.6 & A, 12-29-00; A, 06/01/06; A, 06/30/09]

1.14.2.7 DEFINITIONS:

A. "Agency" means any state agency, department, bureau, board, commission, institution or other organization of the state government, including district courts. See Sections 14-3-2 and 14-3-15 NMSA 1978.

B. "Approved microphotography system" means a microphotography system that has been approved in writing by the administrator under the provisions of Section 14-3-15 NMSA 1978.

C. "CD-ROM mastering process" means the creation of the first recording (the master) in the compact disk-read only memory replication process.

D. "CD-ROM premastering" see premastering.

E. "Compact disk" means read-only optical disk available in formats for audio, data and other information.

F. "Compact disk-read only memory" means optical disk that is created by a mastering process and used for reading.

G. "Compact disk-write once read many" means an optical disk that is written and then available for reading.

H. "Density" means the light-absorbing or light-reflecting characteristics of a photographic image, filter, etc.; or the number of pixels per square inch.

I. "Document accountability" means the process whereby original documents are compared against the images produced, so that the film ensures the validity and integrity of the images.

J. "Dots per inch" means the measurement of output device resolution and quality, e.g., number of pixels per inch on display device. Measures the number of dots horizontally and vertically.

K. "Enhancement algorithms" means the set of techniques for processing an image so that the result is visually clearer than the original image.

L. "JPEG" means the specific compressed image file format specified by ISO. [See JPEG acronym]

M. "Imaging" means the process of converting human readable media, such as paper or microfilm, into information that can be stored and retrieved electronically.

[~~M.~~] **N.** "Master" (noun) means:

(1) in micrographics, the original microform produced from which duplicates or intermediates can be obtained (ISO); and

(2) in electronic imaging, the first recording, one from which duplicates can be obtained.

[~~N.~~] **O.** "Master" (verb) means creating the first recording.

[~~O.~~] P. "Microphotography" means the transfer of images onto storage media including but not limited to film, tape, disk, or other information storage techniques that meet the Performance Guidelines for Legal Acceptance of Public Records produced by information technology system technologies pursuant to regulations adopted by the commission of public records. See Section 14-3-2 NMSA 1978.

[~~P.~~] **Q.** "Microphotography program manager" means the person responsible for the microphotography system program in a state agency.

[~~Q.~~] **R.** "Microphotography system" means all microphotography equipment, services, policies, procedures and supplies that together create, store and reproduce public records.

[~~R.~~] **S.** "Open system" means a system that implements sufficient open specifications for interfaces, services, and supporting formats to enable properly engineered image processing applications that can be ported with minimal changes across a wide range of systems; can inter-operate with other applications on local and remote systems; and can interact with users in a manner that facilitates access and maintenance of public records on such systems.

[~~S.~~] **T.** "Open system environment" means the comprehensive set of interfaces, services, and supporting formats, plus user aspects, for portability or interoperability of applications and data.

[~~T.~~] U. "Optical disk" means the medium that will accept and retain information in the form of marks in a recording layer that can be read with an optical beam. See also compact disk-read only memory, rewritable optical disk and write-once read many optical disk.

[~~U.~~] V. "Pixel" means the smallest element of a display surface that can be independently assigned color or intensity.

[~~V.~~] W. "Premaster" means the intermediate recording from which a master will be created.

[~~W.~~] X. "Premastering" means the conversion to digital code, the addition of error correction codes and the intelligent preprocessing of the data records. It also includes the phase of optical disk production in which machine-readable and bit-stream data are converted to optical disk.

[~~X.~~] Y. "Records" means information preserved by any technique in any medium, now known, or later developed, that can be recognized by ordinary human sensory capabilities either directly or with the aid of technology.

[~~Y.~~] Z. "Records custodian" means the statutory head of an agency which creates or maintains the records that are being microphotographed, or his designee.

[~~Z.~~] AA. "Resolution" means the ability of a system to record fine detail, or the measure of that fine detail.

[~~AA.~~] BB."Scanner" means a device that converts a document into binary (digital) code by detecting and measuring the intensity of light reflected from paper or transmitted through microfilm.

[~~BB.~~] CC."Tag image file format" means the standardized format for storage of digitalized images, which contains a header or tag that defines the exact data structure of the associated image.

DD. "Traditional microfilm" means the production of traditional microfilm in which source documents are photographed utilizing a camera and images are captured on film.

[7-29-96, 1-12-98; 1.14.2.1.7 NMAC - Rn, 1 NMAC 3.2.60.1.7 & A, 12-29-00; A, 04-30-02; A, 06/01/06, A, 06/30/09]

1.14.2.9 MICROPHOTOGRAPHY SYSTEM APPROVAL:

A. The state records administrator shall approve or disapprove in writing all microphotography system plans for microfilm, COM and imaging. No records shall be destroyed where an unapproved microphotography system is being used. Approval of a microphotography system plan shall be for five years, unless the system is modified (see 1.14.2.16D NMAC). Renewal of approval is contingent upon submission of a five year system review or an amended plan.

B. [~~Agencies shall request in writing the approval of new, modified and existing microphotography systems not previously approved, including but not limited to microfilm, COM and electronic imaging.~~] Agencies shall comply with the requirements in this rule for microfilming or digitizing public records to ensure that the informational content of the record is captured and preserved for the life of the record.

C. [~~A microphotography system plan shall be submitted with the request for approval and the system shall be approved before any paper records are replaced.~~] Agencies shall request in writing the approval of a new, a modified and an existing microphotography system plan not previously approved, including but not limited to microfilm, COM and digital imaging.

(1) Traditional microfilm: microphotography plans for traditional microfilm shall meet all requirements as specified in Sections 9, 10 and 11 of 1.14.2 NMAC.

(2) COM: microphotography plans for computer output microfilm shall meet all requirements as specified in Sections 9, 12, 13 and 14 of 1.14.2 NMAC.

(3) Digital imaging: microphotography plans submitted for digital imaging shall meet all requirements as specified in Sections 9, 14, 15 and 16 of 1.14.2 NMAC.

D. The approval of a microphotography system plan shall be obtained before any source documents are submitted for destruction.

[7-29-96, 1-12-98; 1.14.2.9 NMAC - Rn, 1 NMAC 3.2.60.1.8 & A, 12-29-00, A, 06/30/09]

1.14.2.10 STANDARD FOR MICROFILM: [~~To maintain the integrity of the original records and to ensure that the microfilm produced is an adequate substitute for the original record and serves the purpose for which such records were created and or maintained the following standard shall be adhered to:~~

~~**A.** For agencies conducting on-site microfilm operations, the microphotography program manager and all program staff are encouraged to attend records and information management training provided by the state records center. For an agency utilizing a service provider for the filming, processing, duplication or storage of microfilm, the agency shall have a written agreement in place to provide for compliance with this standard.~~

~~**B.** A microfilm system shall be determined to meet the minimum standards of the New Mexico commission of public records if the combined results of the consumables (i.e. film, chemicals, etc.) and microfilm equipment meet the standards developed or approved by the American national standards institute for the production of microfilm (see 1.14.2.17 NMAC). The requirements of the most current revisions of said standard shall prevail unless otherwise specified in this rule.~~

~~**C.** The microfilm shall be complete and contain all information shown on the original records.~~

~~**D.** Documents from different record series may be filmed on a single roll provided destruction dates coincide.~~

~~**E.** State agencies shall maintain an index for the purpose of tracking all records microfilmed.~~

~~**F.** Methylene blue test.~~

~~**(1)** For records possessing a permanent retention, a methylene blue test shall be conducted on a six inch unexposed clear strip of leader cut from a processed roll of microfilm. The methylene blue test shall be conducted on the microfilm strip within two weeks after the processing of the microfilm with the test results provided to the SRCA.~~

~~**(2)** Systems producing more than 10 rolls per week, shall maintain proof of biweekly test results.~~

~~**(3)** Residual thiosulphate ion shall not exceed 1.4 micrograms per square centimeter as tested by the methylene blue test.~~

~~**(4)** Test results shall be maintained for the retention period of the records on microfilm produced (until film is eligible for destruction) or until the microfilm is regenerated.~~

~~**(5)** Annual proof of methylene blue testing shall be submitted to the state records center and archives by the end of each fiscal year in which microfilm is produced.~~

~~**G.** Resolution. The required resolution for source document microfilm is based on filming a microcopy test chart.~~

~~**(1)** Rotary cameras. A minimum resolving power of 2.5 shall be read on the required test chart.~~

~~**(2)** Planetary cameras. A minimum resolving power of 4.0 shall be read on the required test chart.~~

~~**(3)** Resolution readings shall be determined by following the procedures for determining microfilm resolution as set forth in ANSI/AIIM MS23.~~

~~**(4)** The required test chart shall appear at the beginning and end of each roll.~~

~~**H.** Density maximum (Dmax). The required background transmission density (relative Dmax) for source document microfilm is based on filming a~~

target consisting of a blank sheet of 20 lb white bond paper.

(1) Paper records dated prior to 1960, the relative Dmax shall read between .9 and 1.19.

(2) Paper records dated 1960 and after, the relative Dmax shall read between .85 and 1.29.

(3) Density targets shall appear at the beginning and end of each roll.

(4) Density readings shall be measured at the center of the density target.

I. Density minimum (Dmin). The required base plus fog density (relative Dmin) for unexposed processed microfilms shall not exceed 0.10.

J. Splicing and erasures. Roll form master negative microfilm shall have no splicing or erasures between certification statements, unless expungement of a particular image or images is authorized in writing by the custodial agency.

K. Statement of intent and purpose. A certification statement shall be filmed as the first and last document on the roll of film. For roll form microfilm, a statement of intent and purpose shall be filmed at the beginning and end of each roll of film.

L. Certification plaque for filmstrip form microfilm:

(1) A certification plaque shall be filmed at the beginning and end of each filmstrip.

(2) No splicing or erasures are allowed between the certification plaques, unless expungement of a particular image or images is authorized in writing by the custodial agency.

M. Each roll of source document microfilm shall be identified by a start of roll target and an end of roll target.

N. Master negative microfilm shall be inspected by state agencies or by vendors filming for agencies. Inspection shall consist of verification of the following:

(1) targets;

(2) indexing;

(3) labeling;

(4) document accountability;

(5) density;

(6) resolution; and

(7) visual observation of major defects and errors.

O. Master microforms stored at the state records center are subject to audit by the state records center and archives staff at any time and shall comply with the standards set out in Subsection N of 1.14.2.10 NMAC. In the event densitometer readings by an agency or vendor consistently vary from those of the SRCA, the agency or vendor shall calibrate their densitometers to correspond to readings obtained by densitometers at the state records center.

P. Agencies shall inspect duplicate film for the following:

(1) major defects and errors;

(2) indexing accuracy;

(3) document accountability; and

(4) legibility.

Q. Microforms failing to pass inspection by the agency or the vendor filming for the agency shall be refilmed.

R. Disposition of originals.

(1) Prior to the final disposition of any microfilmed paper records, all requirements of this rule shall be met.

(2) Agencies shall submit a request for destruction which includes the following information:

(a) a statement that the records for destruction have been microfilmed;

(b) that the microfilm has been filmed in accordance to NM microphotography standards;

(c) roll numbers;

(d) record series; and

(e) shall be signed by the records custodian for destruction approval.

(3) Agencies not required to submit a request for destruction to the NM state records center shall maintain a certificate of record destruction, which meets the requirements of the Public Records Act. This certificate shall include:

(a) a statement that the records for destruction have been microfilmed;

(b) that the microfilm has been filmed in accordance to NM microphotography standards;

(c) roll numbers;

(d) record series; and

(e) shall be signed by the records custodian for destruction approval.

S. Labeling of all master microfilm roll containers

(1) All master microfilm roll containers shall contain the following minimum information:

(a) name and address of the custodial agency;

(b) date filmed;

(c) identification of the first and last document on the roll of film;

(d) identification of the inclusive dates of the oldest and the most recent document by month, date and year;

(e) records series names and corresponding records retention and disposition schedule item number;

(f) disposition trigger date (i.e., date file closed, date contract terminated, etc.);

(g) name and address of the entity producing the roll of film; and

(h) roll number.

(2) Master microfilm rolls that do not contain the required information on the label shall be returned to the agency for relabeling. If SRCA is required to ship the master microfilm rolls back to the agency, the custodial agency shall be responsible for the shipping costs.

T. Microfilm targets. The following targets shall be used to be in compliance with this rule:

(1) Statement of intent and purpose. Statement of intent and purpose contains the following information:

(a) authority under which microfilming is being done;

(b) name of the agency for which the microfilming is being done;

(c) statement that the records microfilmed are the actual records of the ageney, and that the records were created as part of the normal course of business;

(d) statement that it is the policy of the agency to microfilm specified records as part of the normal course of business, and (when applicable) that the backlog shall be microfilmed as part of a conversion process to maintain a valid and cost efficient record keeping program;

(e) statement that it is the policy of the agency to microfilm specified records to maintain as the legal copy of record in lieu of paper, and that the paper records are destroyed after microfilming in accordance with all requirements of the Public Records Act; and

(f) name, title, and signature of records custodian or microphotography program manager.

(2) Certification plaque:

(a) certification plaque A shall be filmed on the first and last image of a filmstrip; and

(b) certification plaque B shall be filmed on single image filmstrips, such as aperture cards.

(3) Resolution target. An original chart shall be utilized for filming.

(4) Density target. A 20lb. bond sheet of paper shall be utilized for filming.

(5) Start of roll target. Start of roll target shall contain the following information:

(a) roll number;

(b) name of ageney and office to which the records belong;

(c) record(s) or file(s) being microfilmed;

(d) date of filming;

(e) name of camera operator; and

(f) description of first record image on the roll of film.

(6) End of roll target. End of roll target shall contain the following information:

(a) roll number;

(b) name of ageney and office to which the records belong;

(c) record(s) or file(s) being microfilmed;

(d) date of filming and name of camera operator; and

(e) description of last record

~~image on the roll of film.~~

~~**U.** Microfilm image sequence and spacing. The following image sequence and spacing shall be used:~~

~~**(1)** Start of roll:~~

~~**(a)** film leader;~~

~~**(b)** a single statement of intent and purpose;~~

~~**(c)** a single resolution target;~~

~~**(d)** a single density target;~~

~~**(e)** a single start of roll target; and~~

~~**(f)** four spaces.~~

~~**(2)** Record images. Source documents are to be filmed between the start and end of roll targets.~~

~~**(3)** End of roll:~~

~~**(a)** four spaces;~~

~~**(b)** a single end of roll target;~~

~~**(c)** a single density target;~~

~~**(d)** a single resolution target;~~

~~**(e)** a single statement of intent and purpose; and~~

~~**(f)** film trailer.~~

~~**V.** The agency shall maintain an index for the purpose of tracking all microphotography records. The index shall identify individual records by relevant use and criteria.~~

~~**(1)** Indexing requirements shall vary from agency to agency, and, within an agency document type by document type. An indexing schema shall take into consideration compliance with freedom of information laws. Indexing requirements include:~~

~~**(a)** Data elements required for search and retrieval shall be defined by each submitting agency for each record series. Access requirements of current and future end users shall be considered.~~

~~**(b)** Objective coding elements are those identifiers that do not require subjective assessment. Examples of objective coding elements include document date, document type, author, recipient, etc.~~

~~**(2)** Indexing retrieval software. Where an automated index is selected, the software used to search the index and to display index records found shall address user interface issues.~~

~~**W.** All master negative microfilm shall be stored off site (for security purposes) for the full period prescribed by the agency's records retention and disposition schedule.~~

~~**X.** An agency shall produce a minimum of one working copy of microfilm.~~

~~**Y.** Master microfilm that does not meet the minimum standards for the production of master microfilm specified in this section for density, resolution, targeting and spacing shall fail inspection and shall be re-filmed.~~

~~**Z.** An agency shall have a re-inspection program and process in place for all master microfilm produced.~~] This standard applies to the production of traditional microfilm in which source documents are photographed utilizing a camera and images are captured on film. The measures outlined in this section are required to maintain the integrity of the original records and to ensure that the microfilm produced is an adequate substitute for the original record and serves the purpose for which such records were created.

A. Agencies utilizing a service provider for the filming, processing, duplication or the production of microforms shall have a written agreement in place to provide for compliance with this standard.

B. A microfilm system shall be determined to meet minimum standards if the combined results of the consumables (i.e. film, chemicals, etc.) and microfilm equipment meet the standards developed or approved by the American national standards institute for the production of microfilm (see 1.14.2.17 NMAC). The requirements of the most current revisions of said standard shall prevail unless otherwise specified in this rule.

C. Preparation for microfilming: Materials to be microfilmed require careful analysis and preparation to ensure the creation of quality microfilm that is readily usable and easily understood. Important factors to be considered in determining which record series should be filmed include retention period and volume. Only records in large volume or with long retention periods should normally be considered. Before microfilming, materials must be properly organized and collated.

(1) Records shall be carefully inspected for completeness and the description and retention period of the record verified.

(2) The proper order of the materials shall be determined before microfilming.

(3) Active records shall not be filmed with inactive records.

(4) Documents from different record series may be filmed on a single roll provided retention periods are the same.

D. Microfilm qualifications: Agencies shall produce a *master* negative microfilm and a *working copy.* An agency shall have a re-inspection program and process in place for all master microfilm produced.

(1) Master microfilm shall:

(a) be of a silver gelatin composition;

(b) meet the minimum standards for the production of master microfilm specified in this section for density, resolution, targeting and spacing;

(c) shall be re-filmed if it fails inspection;

(d) be stored off-site (for security purposes) for the full period prescribed by the agency's records retention and disposition schedule.

(2) Working copy microfilm is designated for reference or everyday use in an office and may be of silver halide, diazo, or of a vesicular composition. An agency shall produce a minimum of one working copy of microfilm.

(3) If multiple working copies of security or preservation microfilm are needed, it is recommended that the production of such microfilm conform to a three-generation system as noted in section 7.1 of ANSI/AIIM MS48-1990. Such a system consists of master negative; a second-generation copy of the master negative that serves as a duplicate negative to be used for producing additional copies; and one or more third-generation working copies produced from the second-generation film.

(4) Agencies using microfilm systems that do not produce an original silver gelatin film shall make a silver gelatin duplicate negative that meets this standard before depositing such film for storage at the SRCA.

E. Microfilm targets. All microfilm shall have the following targets to be in compliance with this rule:

(1) Statement of intent and purpose. A statement of intent and purpose shall be filmed at the beginning and end of each roll of film and shall contain the following information:

(a) authority under which microfilming is being done;

(b) name of the agency for which the microfilming is being done;

(c) statement indicating the records microfilmed are in the legal custody of the agency, and that the records were created as part of the normal course of business;

(d) statement certifying the agency is microfilming in accordance with an approved microphotography plan on file with the SRCA;

(e) statement certifying that it is the policy of the agency to microfilm the specified records and that the microfilm is an accurate representation of the original copy which will be maintained as the legal copy of record in lieu of paper, and that the paper records are destroyed after microfilming in accordance with all requirements of the Public Records Act; and

(f) name, title, and signature of records custodian or microphotography program manager.

(2) Resolution target. Each roll of film will contain a photographic image of a standard resolution test card or chart. ISO test chart no. 2 as specified by ANSI/AIIM MS51-1991 (*American National Standard*

for Microcopying—ISO Test Chart No. 2—Description and Use in Photographic Documentary Reproduction), must be filmed at the beginning and ending of each roll. These chart images should be used to monitor resolution as filming progresses. The line patterns must be read in each corner and in the center of each chart (or on a diagonal for rotary cameras) and the lowest resolution reading must be posted to the film container and to the guide sheet or other laboratory record. The cause of a substandard resolution must be identified and corrected prior to further production filming. All substandard film shall be corrected before shipping to the SRCA for storage.

(a) Rotary cameras. A minimum resolving power of 2.5 shall be read on the required test chart.

(b) Planetary cameras. A minimum resolving power of 4.0 shall be read on the required test chart.

(c) Resolution readings shall be determined by following the procedures for determining microfilm resolution as set forth in ANSI/AIIM MS23.

(3) Density target. The required background transmission density maximum (Dmax) for source document microfilm is based on filming a target consisting of a blank sheet of 20 lb white bond paper.

(a) Paper records dated prior to 1960, the relative Dmax shall read between .9 and 1.19.

(b) Paper records dated 1960 and after, the relative Dmax shall read between .85 and 1.29.

(c) Density targets shall appear at the beginning and end of each roll.

(d) Density readings shall be measured at the center of the density target.

(e) Density minimum (Dmin). The required base plus fog density (relative Dmin) for unexposed processed microfilms shall not exceed 0.10.

(4) Start of roll target. Start of roll target shall contain the following information:

(a) roll number;

(b) name of agency and office to which the records belong;

(c) record(s) or file(s) being microfilmed;

(d) date of filming;

(e) name of camera operator; and

(f) description of first record image on the roll of film.

(5) End of roll target. End of roll target shall contain the following information:

(a) roll number;

(b) name of agency and office to which the records belong;

(c) record(s) or file(s) being microfilmed;

(d) date of filming and name of camera operator; and

(e) description of last record image on the roll of film.

F. Microfilm image sequence and spacing. The following image sequence and spacing shall be used:

(1) Start of roll:

(a) film leader;

(b) a single statement of intent and purpose;

(c) a single resolution target;

(d) a single density target;

(e) a single start of roll target; and

(f) four spaces.

(2) Record images. Source documents are to be filmed between the start and end of roll targets.

(3) End of roll:

(a) four spaces;

(b) a single end of roll target;

(c) a single density target;

(d) a single resolution target;

(e) a single statement of intent and purpose; and

(f) film trailer.

G. Chemical testing of processed film will be required in order to comply with the standards set forth in ANSI/NAPM IT9.17-1993, ANSI/ISO 417-1993 (*American National Standard for Photography—Determination of Residual Thiosulfate and Other Related Chemicals in Processed Photographic Materials—Methods Using Iodine-Amylose, Methylene Blue and SilverSulfide*). Methylene blue test will be used to meet this requirement.

(1) For records possessing a permanent retention, a methylene blue test shall be conducted on a six inch unexposed clear strip of leader cut from a processed roll of microfilm. The methylene blue test shall be conducted on the microfilm strip within two weeks after the processing of the microfilm.

(2) Systems producing more than 10 rolls per week, shall maintain proof of biweekly test results.

(3) Residual thiosulphate ion shall not exceed 1.4 micrograms per square centimeter as tested by the methylene blue test.

(4) Test results shall be maintained for the retention period of the records on microfilm produced (until film is eligible for destruction) or until the microfilm is regenerated.

(5) Annual proof of methylene blue testing shall be submitted to the state records center and archives by the end of each fiscal year in which microfilm is produced.

H. Splicing and erasures. Roll form master negative microfilm shall have no splicing or erasures between certification statements, unless expungement of a particular image or images is authorized in writing by the custodial agency.

I. Post-film inspection:

(1) Master negative microfilm shall be inspected by state agencies or by vendors filming for agencies. Inspection shall consist of verification of the following:

(a) targets;

(b) indexing;

(c) labeling;

(d) document accountability;

(e) density;

(f) resolution; and

(g) visual observation of major defects and errors.

(2) Agencies shall inspect duplicate film for the following:

(a) major defects and errors;

(b) indexing accuracy;

(c) document accountability; and

(d) legibility.

(3) Microforms failing to pass inspection shall be refilmed.

J. Master microforms stored at the state records center are subject to audit by the SRCA at any time and shall comply with the standards set out in Subsection I of 1.14.2.10 NMAC. In the event densitometer readings by an agency or vendor consistently vary from those of the SRCA, the agency or vendor shall calibrate their densitometers to correspond to readings obtained by densitometers at the SRCA.

K. Microfilm container identification.

(1) All master microfilm roll containers shall contain the following minimum information:

(a) name and address of the custodial agency;

(b) date filmed;

(c) identification of the first and last document on the roll of film;

(d) identification of the inclusive dates of the oldest and the most recent document by month, date and year;

(e) records series names and corresponding records retention and disposition schedule item number;

(f) disposition trigger date (i.e., date file closed, date contract terminated, etc.);

(g) name and address of the entity producing the roll of film; and

(h) roll number.

(2) Master microfilm rolls that do not contain the required information on the label shall be returned to the agency for relabeling. If SRCA is required to ship the master microfilm rolls back to the agency, the custodial agency shall be responsible for the shipping costs.

L. Indexing requirements. The agency shall maintain an index for the purpose of tracking all microphotography records. The index shall include the following:

(1) agency code;

(2) record series title and corresponding records retention and disposition schedule item number;

(3) retention period;

(4) inclusive dates;

(5) trigger date;

(6) date filmed; and

(7) access restrictions.

M. Destruction of original copy.

(1) Prior to the final destruction of any microfilmed paper records, all requirements of this rule shall be met.

(2) Agencies shall submit a request for destruction which includes the following information:

(a) a statement that the records for destruction have been microfilmed;

(b) that the microfilm has been filmed in accordance to 1.14.2. NMAC microphotography standards;

(c) roll numbers;

(d) record series; and

(e) shall be signed by the records custodian for destruction approval.

[9-8-77, 5-27-79, 1-7-81, 1-13-82, 3-29-92, 4-6-92, 7-29-96, 8-24-96, 1-12-98; 1.14.2.10 NMAC - Rn, 1 NMAC 3.2.60.1.9& A, 12-29-00; A, 04-30-02; A, 07-15-03; A, 06/01/06, A, 06/30/09]

1.14.2.12 STANDARD FOR COMPUTER OUTPUT MICROFILM (COM): [~~To maintain the integrity of the original records and to ensure that the COM produced is an adequate substitute for the original record and serves the purpose for which such records were created and or maintained, the following standard shall be adhered to:~~

A. ~~A COM system shall be determined to meet the minimum standards of the New Mexico commission of public records if the combined results of the consumables (i.e. film, chemicals, etc.) and equipment producing COM meet the standards developed and or approved by the American national standard institute (see 1.14.2.17 NMAC). The requirements of the most current revision of the standard shall prevail, unless otherwise specified in this rule.~~

B. ~~An agency intending to place records on COM shall complete a COM statement of intent and purpose (form SRCA 2000-5) and submit it to the state records center for approval by the administrator.~~

C. ~~The approved COM statement of intent and purpose shall be used as the target in producing COM. The state records center shall maintain a copy of the statement on file.~~

D. ~~Methylene blue test.~~

(1) ~~Residual thiosulphate ion shall not exceed 1.4 micrograms per square centimeter as tested by the methylene blue test.~~

(2) ~~Annual proof of methylene blue testing shall be submitted to the state records center and archives by the end of the fiscal year in which COM is produced.~~

(3) ~~Test results shall be maintained until COM is eligible for destruction.~~

E. ~~Master negative COM shall have a minimum resolution of 2.8 as read on the test chart prescribed in ANSI/AIIM MS 1-1996. The COM unit shall be tested for resolution adherence each day of operation.~~

F. ~~The density of master negative COM shall be no less than 1.5. The COM unit shall be tested for density adherence each day of operation.~~

G. ~~Each computer output microfiche shall have an identifier image as part of the microfiche index. The image shall include title of record being filmed, creating agency, and date filmed.~~

H. ~~All master negative COM shall be stored off site (for security purposes) for the full period prescribed by the agency's records retention and disposition schedule.~~

I. ~~An agency shall produce a minimum of one working copy of COM.~~

J. ~~Master negative film shall be inspected by state agencies or by vendors filming for agencies. Inspection shall consist of verification of the following:~~

(1) ~~targets;~~

(2) ~~indexing;~~

(3) ~~labeling;~~

(4) ~~document accountability;~~

(5) ~~density;~~

(6) ~~resolution; and~~

(7) ~~visual observation of major defects and errors.~~

K. ~~Master microforms stored at the state records center are subject to audit by the state records center and archives staff at any time and shall comply with the standards set out in Subsection J of 1.14.2.12 NMAC. In the event densitometer readings by an agency or vendor consistently vary from those of the SRCA the agency or vendor shall calibrate their densitometers to correspond to readings obtained by densitometers at the state records center.~~

L. ~~COM failing to pass inspection by the agency or the vendor filming for the agency shall be remastered.~~

M. ~~Agencies shall inspect duplicate COM for the following:~~

(1) ~~major defects and errors;~~

(2) ~~indexing accuracy;~~

(3) ~~document accountability; and~~

(4) ~~legibility.~~

N. ~~Disposition of original records.~~

(1) ~~Prior to the final disposition of any microphotographed paper records, all requirements of this rule shall be met.~~

(2) ~~Agencies shall submit a request for destruction which includes the following information:~~

(a) ~~a statement that the records for destruction have been microphotographed;~~

(b) ~~that the COM has been mastered in accordance to NM microphotography standards;~~

(c) ~~envelope numbers;~~

(d) ~~record series; and~~

(e) ~~shall be signed by the records custodian for destruction approval.~~

(3) ~~Agencies not required to submit a request for destruction to the state records center shall maintain a certificate of record destruction, which meets the requirements of the Public Records Act. This certificate shall include:~~

(a) ~~a statement that the records for destruction have been placed on COM;~~

(b) ~~that the COM has been mastered in accordance to NM microphotography standards;~~

(c) ~~envelope numbers;~~

(d) ~~record series; and~~

(e) ~~shall be signed by the records custodian for destruction approval.~~

O. ~~Labeling of all master microform containers~~

(1) ~~All master microform containers shall contain the following minimum information:~~

(a) ~~name and address of the custodial agency;~~

(b) ~~date filmed;~~

(c) ~~identification of the first and last document on the COM;~~

(d) ~~identification of the inclusive dates of the oldest and the most recent document by month, date and year;~~

(e) ~~record series names and corresponding records retention and disposition schedule item number;~~

(f) ~~disposition trigger dates (i.e., date file closed, date contract terminated, etc.);~~

(g) ~~name and address of the entity producing the COM; and~~

(h) ~~envelope number.~~

(2) ~~Master microform containers that do not contain the required information shall be returned to the agency for re-labeling. If SRCA is required to ship the master microform containers back to the agency, the custodial agency shall be responsible for the shipping costs.~~

P. ~~The agency shall maintain an index for the purpose of tracking all microphotography records. The index shall identify individual records by relevant use and criteria.~~

(1) ~~Indexing requirements shall~~

~~vary from agency to agency, and, within an agency document type by document type. An indexing schema shall take into consideration compliance with freedom of information laws. Indexing requirements include:~~

~~(a) Data elements required for search and retrieval shall be defined for each record series by the submitting agency. Access requirements of current and future end users shall be considered.~~

~~(b) Objective coding elements such as document date, document type, and name of author or recipient shall be identified.~~

~~(2) Indexing retrieval software shall address user interface issues where microphotography images are stored on COM.~~] These standards apply to the production of master microfilm from records digitally created (born digital) or imaged (scanned) from paper. The SRCA recognizes that producing quality microfilm, directly from digital images offers the greatest potential for ensuring the preservation of electronic permanent records or those with a retention period greater than 15 years. Recommended ANSI/AIIM MS1-1996 practices for addressing operational procedures related to alphanumeric COM provide the necessary controls to ensure reasonable quality control for digital-to-film technology.

A. A COM system shall be determined to meet the minimum standards of the New Mexico commission of public records if the combined results of the consumables (i.e., film, chemicals, etc.) and equipment producing COM meet the standards developed and approved by the ANSI/AIIM MS1-1996 (see 1.14.2.17 NMAC). The requirements of the most current revision of the standard shall prevail, unless otherwise specified in this rule.

B. The following standards for production, testing, and inspection of COM shall be met:

(1) ANSI/AIIM MS1;
(2) ANSI/AIIM MS5;
(3) ANSI/AIIM MS28;
(4) ANSI/AIIM MS39;
(5) ANSI/AIIM MS43; and
(6) ANSI/NAPM IT9.17.

C. Record grouping. Before converting images to COM records shall be properly organized and grouped.

(1) Records shall be carefully inspected for completeness and the description and retention period of the record verified.

(2) The proper order of the materials shall be determined before conversion to COM.

(3) Active records shall not be filmed with inactive records.

(4) Documents from different record series may be filmed on a single roll provided retention periods are the same.

D. Quality monitoring of scanner. All operations using the digital-to-film process shall follow procedures outlined in ANSI/AIIM MS44 *Recommended Practice for Quality Control of Image Scanners.* The AIIM *Scanner Test Chart #2*shall be scanned weekly on each scanner and included at the front and end of each roll. The scan chart at the beginning shall correspond to the week of the earliest scanned record on the roll, and the one at the end shall be scanned during the week of the last scanned record on the roll. The date that each chart was scanned must be displayed on the film. Additionally, a control scanned image of AIIM *Scanner Test Chart #2* shall be created once as a control image and placed directly preceding the weekly test chart on each roll of film. The purpose is to easily compare variations in quality over long periods of time. It is vital that the test charts used are scanned on the same equipment that processed the source documents on the film. Charts scanned on one piece of equipment shall never be used on reels with images from another scanner.

E. Quality monitoring of images. Each image shall be visually compared against its corresponding original document in order to identify and correct the following defects:

(1) missing pages;
(2) page skew;
(3) text cutoff at edges;
(4) double-page feeds;
(5) contrast problems; and
(6) images in a different order than originals.

F. Resolution test targets:

(1) COM produced from scanned or born digital images shall include resolution charts as recommended in ANSI/AIIM MS 44 1993 *Recommended Practice for COM Recording Systems Having an Internal Electronic Forms Generating System-Operational Practices for Inspection and Quality Control*.

(2) The COM unit shall be tested for resolution adherence each day of operation.

G. Density: The minimum background density on microfilm output shall bewithin the ranges prescribed in ANSI/AIIM MS 1-1996 *Standard Recommend Practice for Alphanumeric Computer-Output Microforms - Operational Practices for Inspection and Quality Control*.

(1) Density of master negative COM shall measure between 0.80 to 1.20.

(2) Required base plus fog density (relative Dmin) for unexposed processed microfilms shall not exceed 0.10.

(3) Background density on positive appearing silver masters shall be no greater than 0.30.

(4) The COM unit shall be tested for density adherence each day of operation.

H. Reduction ratios: The reduction chosen for COM shall be consistent with recommended practices for microfilm of records of permanent retention. A reduction ratio not exceeding 48:1 is required.

I. Image resolution: Resolution shall be adequate to duplicate all details of the document in order that the COM qualify as a true copy of the original record.

(1) An image resolution of 300 dpi shall be used for text.

(2) Smaller fonts or fonts that contain detailed serifs require a resolution of 400 to 600 dpi range depending on the characteristics in the font that are to be preserved.

(3) Photographs and other halftone records shall have a scanning resolution of 600 dpi.

(4) Engineering, surveying and other records which require precise measurement shall be scanned at a sufficiently high resolution to provide for adequate representation of the original record.

J. Image formats. Digital images shall be in a standard image format such as Group IV TIFF, BMP or PDF.

K. Blip coding. To effectively organize a roll of COM the use of a multi-level blip coding strategy may be used. Blips are rectangular marks exposed by the film recorder under each page as they are written on the film. These marks can be programmed to appear in different sizes to identify file level, document level, page level, etc. images. Applying this sequence to recorded documents, a large blip designates the first page of a document while small blips indicate supporting pages within the document.

L. Page orientation. Pages can be recorded on microfilm in two ways. In “cine mode” where the text on a page runs perpendicular to the length of the film and in “comic mode” where the text on a page runs parallel to the length of the film. Unless a lower reduction ratio is needed for acceptable image quality, recording letter and legal sized pages in comic mode is preferable. This is accomplished by rotating the images 90º prior to recording or feeding the page “sideways” through the scanner. The advantage of comic mode recording is that more pages can be written on each roll of film saving storage space and promoting more efficient scanning in the event that the film needs to be used to recover lost image data.

M. Page spacing. Pages need to have sufficient separation to allow a film scanner to reliably differentiate adjacent pages on the film. There should be a minimum separation of 0.06” (1.5mm)

between adjacent pages. Pages that touch each other at any point may preclude them from being captured separately by a microfilm scanner. Although maximizing packing density improves scanning efficiency, documents recorded on film should not span rolls.

N. Microfilm targets. All microfilm shall have the following targets to be in compliance with this rule:

(1) Statement of intent and purpose. A statement of intent and purpose shall be filmed at the beginning and end of each roll of film and shall contain the following information:

(a) authority under which microfilming is being done;

(b) name of the agency for which the microfilming is being done;

(c) statement indicating the records microfilmed are in the legal custody of the agency, and that the records were created as part of the normal course of business;

(d) statement certifying the agency is microfilming in accordance with an approved microphotography plan on file with the SRCA;

(e) statement certifying that it is the policy of the agency to microfilm the specified records and that the microfilm is an accurate representation of the original copy which will be maintained as the legal copy of record in lieu of paper, and that the paper records are destroyed after microfilming in accordance with all requirements of the Public Records Act; and

(f) name, title, and signature of records custodian or microphotography program manager.

(2) Resolution test targets. COM produced from either scanned or born digital images shall include resolution charts as recommended in ANSI/AIIM MS 44 1993 *Recommended Practice for COM Recording Systems Having an Internal Electronic Forms Generating System - Operational Practices for Inspection and Quality Control.*

(3) Density targets. See Subsection G of 1.14.2.12 NMAC.

(4) Start of roll target. Start of roll target shall contain the following information:

(a) roll number;

(b) name of agency and office to which the records belong;

(c) record(s) or file(s) being microfilmed;

(d) date of filming;

(e) name of camera operator; and

(f) description of first record image on the roll of film.

(5) End of roll target. End of roll target shall contain the following information:

(a) roll number;

(b) name of agency and office to which the records belong;

(c) record(s) or file(s) being microfilmed;

(d) date of filming and name of camera operator; and

(e) description of last record image on the roll of film.

O. Microfilm image sequence and spacing. The following image sequence and spacing shall be used:

(1) Start of roll:

(a) film leader;

(b) a single statement of intent and purpose;

(c) a single resolution target;

(d) a single density target;

(e) a single start of roll target; and

(f) four spaces.

(2) Digital or scanned images.

(3) End of roll:

(a) four spaces;

(b) a single end of roll target;

(c) a single density target;

(d) a single resolution target;

(e) a single statement of intent and purpose; and

(f) film trailer.

P. Microfilm qualifications: Agencies shall produce a *master* negative microfilm and a *working copy.* An agency shall have a re-inspection program and process in place for all master microfilm produced.

(1) Master microfilm shall:

(a) be of a wet silver gelatin composition;

(b) meet the minimum standards for the production of master microfilm specified in this section for density, resolution, targeting and spacing.

(c) shall be re-mastered if it fails inspection.

(d) be stored off-site (for security purposes) for the full period prescribed by the agency's records retention and disposition schedule.

(2) Working copy microfilm is designated for reference or everyday use in an office and may be of silver halide, diazo, or of a vesicular composition. An agency shall produce a minimum of one working copy of microfilm.

(3) If multiple working copies of security or preservation microfilm are needed, it is recommended that the production of such microfilm conform to a three-generation system as noted in section 7.1 of ANSI/AIIM MS48-1990. Such a system consists of master negative; a second-generation copy of the master negative that serves as a duplicate negative to be used for producing additional copies; and one or more third-generation working copies produced from the second-generation film.

(4) Agencies using COM systems that do not produce an original silver gelatin film shall make a silver gelatin duplicate negative that meets this standard before depositing such film for storage at the SRCA.

Q. Master COM shall be inspected by state agencies or by vendors filming for agencies. Inspection shall consist of verification of the following:

(1) targets;

(2) indexing;

(3) labeling;

(4) document accountability;

(5) density;

(6) resolution; and

(7) visual observation of major defects and errors.

R. Master COM stored at the SRCA are subject to audit by the SRCA staff at any time and shall comply with the standards set out in Subsection Q of 1.14.2.12 NMAC.

S. Microfilm container identification.

(1) All master microfilm roll containers shall contain the following minimum information:

(a) name and address of the custodial agency;

(b) date converted to COM;

(c) identification of the first and last document on the roll of film;

(d) identification of the inclusive dates of the oldest and the most recent document by month, date and year;

(e) records series names and corresponding records retention and disposition schedule item number;

(f) disposition trigger date (i.e., date file closed, date contract terminated, etc.);

(g) name and address of the entity producing the roll of film; and

(h) roll number.

(2) Master microfilm rolls that do not contain the required information on the label shall be returned to the agency for relabeling. If SRCA is required to ship the master microfilm rolls back to the agency, the custodial agency shall be responsible for the shipping costs.

T. Indexing requirements. The agency shall maintain an index for the purpose of tracking all microphotography records. The index shall include the following:

(1) agency code;

(2) record series title and corresponding records retention and disposition schedule item number;;

(3) retention period;

(4) inclusive dates;

(5) trigger date;

(6) date filmed; and

(7) access restrictions.

U. Destruction of original copy.

(1) Prior to the final destruction of any scanned paper records, all requirements of this rule shall be met.

(2) Agencies shall submit a request for destruction which includes the following information:

(a) a statement that the records for destruction have been scanned and converted to COM;

(b) that the microfilm has been filmed in accordance to 1.14.2. NMAC microphotography standards;

(c) roll numbers;

(d) record series; and

(e) shall be signed by the records custodian for destruction approval.

[11-16-82, 12-20-88, 1-19-89, 3-29-92, 7-29-92, 8-24-96; 1.14.2.12 NMAC - Rn, 1 NMAC 3.2.60.1.10 & A, 12-29-00; A, 04-30-02; A, 07-15-03; A, 06/01/06, A, 06/30/09]

1.14.2.14 STANDARD FOR IMAGING: This section is limited in scope to the conversion of documents to digitized images suitable for storage on optical, [~~or~~] magnetic media, or converted to COM. The standards listed in this section are intended to maintain the integrity of the original record and to ensure that the image produced is an adequate substitute for the original record and serves the purpose for which such record was created or maintained.

[~~**A.** Prior to submitting a request for approval of an imaging system an agency shall have in place a management structure for the imaging system.~~

~~**B.** Prior to submitting a request for approval the agency shall ensure that the proposed imaging system meets all legal requirements~~.

~~**C.** Prior to submitting a request for approval of an imaging system the agency shall prepare a risk assessment for each record series which includes the value of the records to the state and the public, and shall assess alternative record storage systems on at least a benefits and usage basis, prior to implementation. The implementation and use of the imaging system shall not limit or hinder public access to public records. Imaging systems shall provide access which is equivalent, or better than, that provided by the previous record storage system~~.

~~**D.** The imaging system shall be an open system. Variants from an open system, such as proprietary hardware, software or formats, shall require justification.~~

~~**E.** Media life expectancy issues.~~

~~**(1)** Life expectancy rating of any media to be employed by an imaging system used for keeping of public records shall correspond to, and not be less than, the retention period of the records, unless otherwise approved.~~

~~**(2)** Where the life expectancy of media is shorter than retention periods of records imaged, migration shall be addressed as a part of the submitted plan for approval. The migration plan shall provide for review of the hardware and software at least every five years. Where it has been determined that the media are not readable by current off-the-shelf equipment, the agency shall provide for migration to current, generally accessible media. This includes the accessibility of the index as well as accessibility of documents.~~

~~**F.** The agency shall verify completeness of image capture. Verification shall be completed before the mastering of an optical or magnetic disk.~~

~~**G.** The agency shall test disks for readability. During production each disk shall be tested for readability. In addition, every year a representative sample of stored disks shall be tested in order to early detect any deterioration.~~

~~**H.** Based upon the value of the records being imaged, the agency shall provide adequate system security and audit functions in accordance with the Performance Guidelines for the Legal Acceptance of Public Records, 1.13.70 NMAC.~~

~~**I.** Scanned images shall meet the following standards.~~

~~**(1)** Scanning resolution shall be 300 DPI optical minimum, for text.~~

~~**(2)** Photographic records and other halftone records shall have a scanning resolution at least equal to the original.~~

~~**(3)** Resolution shall be adequate to duplicate all details of each document in order for that document to qualify as a true copy. Engineering, surveying and other records, the usage of which requires precise measurement, shall be imaged at a sufficiently high resolution to provide for that measurement.~~

~~**(4)** Digitized images shall be legible for all purposes for which the original records might be used. All characters in digitized images shall be clearly formed and fully recognizable without regard to their surrounding contexts.~~

~~**J.** Image and media formats.~~

~~**(1)** Images shall be in a standard image format such as Group IV TIFF or BMP. Compression of images for storage is acceptable if the output resolution requirements for use are met. GIF and JPEG are acceptable compressed formats. Plain black and white "two level" images shall not be converted to JPEG; at least 16 gray levels are necessary before JPEG is a useful gray scale image.~~

~~**(2)** Where optical media is used, file and directory structures shall be compliant with ISO 9660 - High Sierra Level 1 - eight dot three file naming, limited nested subdirectories. Any variance shall be justified.~~

~~**(3)** Where optical media are used for permanent records storage, they shall be of the highest quality available. Any variance shall be justified.~~

~~**K.** Labeling of all master optical media stored at the state records center and archives.~~

~~**(1)** All master optical disc containers shall contain at a minimum the following information:~~

~~**(a)** name and address of the custodial agency;~~

~~**(b)** date mastered;~~

~~**(c)** identification of the first and last document on the disc;~~

~~**(d)** identification of the inclusive dates of the oldest and the most recent document by month, date and year;~~

~~**(e)** records series names and corresponding records retention and disposition schedule item number;~~

~~**(f)** disposition trigger dates (i.e., date file closed, date contract terminated, etc.);~~

~~**(g)** name and address of the entity producing the disc; and~~

~~**(h)** disc or other identification number.~~

~~**(2)** Master optical media that do not contain the required information on the label shall be returned to the agency for re-labeling. If SRCA is required to ship the master optical media back to the agency, the custodial agency shall be responsible for the shipping costs.~~

~~**(3)** For optical media not stored at the SRCA the labeling shall consist of:~~

~~**(a)** agency name;~~

~~**(b)** mastering date; and~~

~~**(c)** the overall content of the optical disk, independent of any index that may be contained on the disk itself.~~

~~**L.** The agency shall maintain an index for the purpose of tracking all microphotography records. The index shall identify individual records by relevant use and criteria.~~

~~**(1)** Indexing requirements will vary from agency to agency, and, within an agency document type by document type. An indexing schema shall take into consideration compliance with freedom of information laws. Indexing requirements include:~~

~~**(a)** Data elements required for search and retrieval shall be defined for each record series by the submitting agency. Access requirements of current and future end-users shall be considered.~~

~~**(b)** Objective coding elements such as document date, document type, and~~

~~name of author or recipient shall be identified.~~

~~(2) Indexing retrieval software shall address user interface issues where microphotography images are stored on optical disks. Software used to access the index and images shall be included with the optical disk as a self-contained package and shall be consistent with licensing restrictions stipulated by the software vendor, if any.~~

~~M. Documents from different record series may be imaged on a single medium (magnetic disk, optical disk, etc.) provided destruction dates coincide, or the disposition plan provides for the maintenance of the media for the longest retention period of any record on the media.~~

~~N. Page counts in physical files shall be verified in the scanned versions and certified as complete prior to mastering or writing the optical disk. The certification of completeness shall be kept on file by the agency.~~

~~O. Expungement issues.~~

~~(1) The system capability to expunge (obliterate all traces of images and their related index entries) shall be required in some instances. The potential for expungement orders shall be addressed in the plan.~~

~~(2) When expungement of records is necessary, the plan shall provide for the remastering of all media that have been modified.~~

~~(3) When expungement of records is necessary, the plan shall provide for all index records and related image files to be obliterated from the database and the image file storage, and from all backup media.~~

~~P. Imaging systems shall meet the imaging standards developed by ANSI and enumerated in section 1-14-2-17 NMAC. If not, adequate justification must be provided. The requirements of the most current revision of the standard shall prevail, unless otherwise specified in this rule.~~

~~Q. Facility issues.~~

~~(1) Imaging systems shall not be operated in environments with high levels of airborne particles. At a minimum, control of airborne particles from source documents shall be addressed in the imaging system plan.~~

~~(2) Imaging systems shall be operated in environments with appropriate controlled access and physical security in conformity with the Performance Guidelines for the Legal Acceptance of Public Records, 1.13.70 NMAC.~~

~~(3) Imaging systems shall be operated in environments with adequate temperature and humidity controls.~~

~~R. New imaging system applications shall be backward compatible with pre-existing applications, or, where they are not, a migration plan for pre-existing images and indexes shall be provided, or dual systems shall be run until the records retention periods for all pre-existing imaged records have expired.~~]

A. All state agencies shall submit an imaging system plan to the state records administrator for approval prior to implementing a digital imaging system for the conversion of paper documents to a digital format. The imaging plan shall address all of the requirements as specified in 1.14.2.14 NMAC.

B. The imaging system shall be an open system. Variants from an open system, such as proprietary hardware, software or formats, shall require justification.

C. Media life expectancy issues.

(1) Life expectancy rating of any media to be employed by an imaging system used for keeping of public records shall correspond to, and not be less than, the retention period of the records, unless otherwise approved.

(2) Where the life expectancy of media is shorter than retention periods of records imaged, migration shall be addressed as a part of the submitted plan for approval. The migration plan shall provide for review of the hardware and software at least every five years. Where it has been determined that the media are not readable by current off-the-shelf equipment, the agency shall provide for migration to current, generally accessible media. This includes the accessibility of the index as well as accessibility of documents.

(3) Digital images converted to COM shall meet all of the requirements specified in Section 1.14.2.12 NMAC.

D. The agency shall verify completeness of image capture. Verification shall be completed before the mastering of an optical, magnetic disk, or conversion to COM.

E. The agency shall test disks for readability. During production each disk shall be tested for readability. In addition, every year a representative sample of stored disks shall be tested in order to early detect any deterioration.

F. Based upon the value of the records being imaged, the agency shall provide adequate system security and audit functions in accordance with the Performance Guidelines for the Legal Acceptance of Public Records, 1.13.70 NMAC.

G. Scanned images shall meet the following standards.

(1) Scanning resolution shall be 300 DPI optical minimum, for text.

(2) Photographic records and other halftone records shall have a scanning resolution at least equal to the original.

(3) Resolution shall be adequate to duplicate all details of each document in order for that document to qualify as a true copy. Engineering, surveying and other records, the usage of which requires precise measurement, shall be imaged at a sufficiently high resolution to provide for that measurement.

(4) Digitized images shall be legible for all purposes for which the original records might be used. All characters in digitized images shall be clearly formed and fully recognizable without regard to their surrounding contexts.

H. Image and media formats.

(1) Images shall be in a standard image format such as Group IV TIFF,PDF or BMP. Compression of images for storage is acceptable if the output resolution requirements for use are met. GIF and JPEG are acceptable compressed formats. Plain black and white "two level" images shall not be converted to JPEG; at least 16 gray levels are necessary before JPEG is a useful gray scale image.

(2) Where optical media is used, file and directory structures shall be compliant with ISO 9660 - High Sierra Level 1 - eight dot three file naming, limited nested subdirectories. Any variance shall be justified.

(3) Where optical media are used for permanent records storage, they shall be of the highest quality available. Any variance shall be justified.

I. Labeling requirements for all master security optical media stored at the SRCA.

(1) All master optical disc containers shall contain at a minimum the following information:

(a) name and address of the custodial agency;

(b) date mastered;

(c) identification of the first and last document on the disc;

(d) identification of the inclusive dates of the oldest and the most recent document by month, date and year;

(e) records series names and corresponding records retention and disposition schedule item number;

(f) disposition trigger dates (i.e., date file closed, date contract terminated, etc.);

(g) name and address of the entity producing the disc; and

(h) disc or other identification number.

(2) Master security optical media that do not contain the required information on the label shall be returned to the agency for re-labeling. If SRCA is required to ship the master optical media back to the agency,

the custodial agency shall be responsible for the shipping costs.

(3) For optical media not stored at the SRCA the labeling shall consist of:

(a) agency name;

(b) date mastered;

(c) record series name and number;

(d) inclusive dates of the records series; and

(e) the overall content of the optical disk, independent of any index that may be contained on the disk itself.

J. The agency shall maintain an index for the purpose of tracking all microphotography records. The index shall include the following:

(1) agency code;

(2) record series title and corresponding records retention and disposition schedule item number;

(3) retention period;

(4) inclusive dates;

(5) trigger date;

(6) date filmed; and

(7) access restrictions.

K. Documents from different record series may be imaged on a single medium (magnetic disk, optical disk, etc.) provided destruction dates coincide, or the disposition plan provides for the maintenance of the media for the longest retention period of any record on the media.

L. Page counts in physical files shall be verified in the scanned versions and certified as complete prior to mastering or writing the optical disk. The certification of completeness shall be kept on file by the agency.

M. Expungement issues.

(1) The system capability to expunge (obliterate all traces of images and their related index entries) shall be required in some instances. The potential for expungement orders shall be addressed in the plan.

(2) When expungement of records is necessary, the plan shall provide for the remastering of all media that have been modified.

(3) When expungement of records is necessary, the plan shall provide for all index records and related image files to be obliterated from the database and the image file storage, and from all backup media.

N. Preservation: Preservation requirements are based on the retention period of the digital image.

(1) Digital records that have an established life cycle of fifteen years or less and are declared the official copy of record may be stored electronically.

(2) Digital records that have a long-term retention requirement of sixteen to fifty years shall meet the requirements specified in Subsection C of 1.14.2.14 NMAC. If converted to COM the requirements of Subsection C do not apply.

(3) Digital records that have a retention period greater than fifty years or have a permanent retention shall be converted to COM. For COM requirements see 1.14.2.11 NMAC and 1.14.2.12 NMAC.

O. Imaging systems shall meet the imaging standards developed by ANSI and enumerated in section 1-14-2-17 NMAC. If not, adequate justification must be provided. The requirements of the most current revision of the standard shall prevail, unless otherwise specified in this rule.

P. New imaging system applications shall be backward compatible with pre-existing applications, or, where they are not, a migration plan for pre-existing images and indexes shall be provided, or dual systems shall be run until the records retention periods for all pre-existing imaged records have expired.

[7-29-96, 8-24-96, 1-12-98; 1.14.2.14 NMAC - Rn, 1 NMAC 3.2.60.1.11 & A, 12-29-00; A, 07-15-03; A, 06/01/06; A, 06/30/09]

1.14.2.17 ADDITIONAL MICROPHOTOGRAPHY STANDARDS. In addition to those non-SRCA standards already incorporated into this rule, it is recommended that agencies employing or anticipating the use of a microphotography system refer to and consider the following national or international standards:

A. ANSI/AIIM MS1-1996 Recommended Practice for Alphanumeric Computer Output Microforms - Operational Practices for Inspection and Quality Control: This recommended practice describes operational and quality control guidelines for alpha-numeric computer output microfilm (COM) recorders and microforms using black & white film as well as duplicates made from such films.

B. ANSI/AIIM MS5-1992 Micrographic Microfiche: This standard applies to microfiche produced as a result of source document and computer-output microfilming.

C. ANSI/AIIM MS6-1993 (R1999) Microfilm Package Labeling: This standard outlines the required and optional information that should be placed on unexposed photographic material packaging.

D. ANSI/AIIM MS14-1996 Specifications for 16 and 35 mm Roll Microfilm: This standard applies to 16mm and 35mm roll microfilm produced as a result of source document and computer output microfilming.

E. ANSI/AIIM MS17-1992 Micrographics — Rotary (Flow) Microfilm Camera Test Chart and Test Target Descriptions and Use: This standard determines the optical performance of rotary microfilm cameras by using test chart outlined in this standard.

F. ANSI/AIIM MS18-1992 Splices for Imaged Film — Dimensions and Operational Constraints: This standard covers the requirements for splicing processed microfilm and leaders and trailers independent of film width or type of base support.

G. ANSI/AIIM MS19-1993 Recommended Practice for Identification of Microforms: This document provides methods for identifying the contents of microforms.

H. ANSI/AIIM MS23-1998 Practice for Operational Procedures/Inspection and Quality Control of First-Generation Silver-Microfilm of Documents: This document discusses equipment, supplies, and recommended practices necessary to establish and operate a satisfactory micrographics program.

I. ANSI/AIIM MS24-1996 Test Target for Use in Micro recording Engineering Graphics on 35mm Microfilm: This standard specifies the minimum test target elements, their composition and other criteria which is utilized by a 35mm planetary microfilm camera when micro recording engineering drawings.

J. ANSI/AIIM MS26-1990 35mm Planetary Cameras (top light) — Procedures for Determining Illumination Uniformity of Microfilming Engineering Drawings: This standard specifies the minimum test target elements and their criteria used in determining the uniformity of illumination on the copy board of a 35mm planetary camera.

K. ANSI/AIIM MS35-1990 Requirements and Characteristics of Original Black and White Documents That May Be Microfilmed: This standard practice describes the essential requirements and characteristics for the creation of documents that will facilitate microfilming.

L. ANSI/AIIM MS36-1990 Reader-Printers for Transparent Microforms-Performance Characteristics: This standard specifies the essential performance to view and make hardcopies from roll microfilm.

M. ANSI/AIIM MS38-1995 Recommended Practices for the Micro recording of Engineering Graphics — Computer Output Microfilm: Specifies the procedures, dimensions, and quality values governing the micro recording of engineering documentation with a 35mm computer-output microfilmer (COM).

N. ANSI/AIIM MS39-1987 Information and Image Management - Operational Procedures, Quality Control and Inspection of Graphic Computer Output Microforms: This document describes operational and quality control guidelines for graphic (COM) recorders and microforms using black and white film and duplicates

made from such films.

O. ANSI/AIIM MS42-1989 Recommended Practice for the Expungement, Deletion, Correction or Amendment of Records on Microforms: This recommended practice applies to the removal of images from microforms when document expungement is ordered.

P. ANSI/AIIM MS43-1998 Recommended Practice for Operational Procedures/Inspection and Quality Control of Duplicate Microforms of Documents and From COM: This document provides guidelines for the production of duplicate microforms.

Q. ANSI/AIIM MS44-1988 (R1993) Recommended Practice for Quality Control of Image Scanners: This practice provides procedures for the ongoing control of quality within a digital document image management system.

R. ANSI/AIIM MS45-1990 Recommended Practice for Inspection of Stored Silver Gelatin Microforms for Evidence of Deterioration: This practice applies to all forms of silver-gelatin microfilm whether in roll, aperture card, jacket or microfiche format.

S. ANSI/AIIM MS48-1999 Recommended Practice for Microfilming Public Records on Silver Halide Film: This practice covers original first-generation microforms including rolls, microfiche, aperture cards, and jacket film.

T. ANSI/AIIM MS51-1991 Micrographics — ISO Resolution Test Chart No.2 Description and Use: This standard specifies a method of determining resolution by measuring the minimum size of detail recognizable in processed microform.

U. ANSI/AIIM MS52-1991 Recommended Practice for the Requirements and Characteristics of Documents Intended for Optical Scanning: This standard describes the physical characteristics of paper documents that facilitate black and white optical scanning.

V. ANSI/AIIM MS61 - 1996 Application Programming Interface (API) for Scanners in Document Imaging Systems.

W. ANSI/AIIM MS62-1999 Recommended Practice for COM Records Systems Having an Internal Electronic Forms Generating System: This standard provides operational practices for inspection and quality control.

X. ANSI/AIIM MS111-1994 Recommended Practice for Microfilming Printed Newspapers on 35mm Roll Microfilm: The purpose of this practice is to establish consistent formats and criteria for microfilming printed newspapers.

Y. ANSI/NAPM IT9.1-1996 Imaging Materials - Processed— Silver — Gelatin Type - Black and White Film Specifications for Stability: Specifies the manufacturing and processing requirements for silver-gelatin film.

Z. ANSI/PIMA IT9.2-1998 Imaging Media — Photographic Processed Films, Plates, and Papers Filing Enclosures and Storage Containers: This standard sets forth the principal physical and chemical requirements for filing enclosures and containers designed for storing processed films, plates, and papers in sheet form.

AA. ANSI/NAPM IT9.6 1991 (R1996) Photographic Films — Specifications for Safety Film: This international standard provides specifications and test procedures for establishing the safety of photographic films with respect to hazards from fire.

BB. ANSI/NAPM IT9.7 1993 Photography - Photographic Films and Papers Wedge Test for Brittleness: This standard specifies a method for determining and expressing quantitatively the brittleness of photographic film. It is applicable to film with or without a gelatin backing and may also be applied to either raw or processed film, although the brittleness of a particular film may be quite different after processing than it was before processing. This is a revision of PH1.31-1973.

CC. ANSI/PIMA-IT9.11 1998 Imaging Media — Processed Safety Photographic Film Storage: The recommendations contained in this standard deal with the storage conditions, storage facilities, and handling and inspection procedures for processed safety photographic film in roll, strip, card, or sheet form, regardless of size.

DD. ANSI/NAPM IT9.14 1992 (R1997) Imaging Media — (Photographic film and papers) — Method for Determining the Resistance of Photographic Emulsions to Wet Abrasion: This standard, a revision and redesignation of ANSI/NAPM IT11 1993, establishes a laboratory test method for determining the resistance of photographic emulsion or gelatin backing to abrasion damage during processing.

EE. ANSI/NAPM IT9.15-1993 Imaging Media — Photography — The Effectiveness of Chemical Conversion of Silver Images Against Oxidation — Method for Measuring: This standard describes methods for evaluating the effectiveness of chemical conversion treatment intended to increase the resistance of wet processed silver images to oxidation.

FF. ANSI/NAPM IT9.17-1993, ANSI/ISO 417-1993 Micrographics - Photography —Determination of Residual Thiosulfate and Other Related Chemicals in Processed Photographic Materials— Methods Using Iodine-Amylose, Methylene Blue and SilverSulfide.

[~~FF.~~] GG. ANSI/NAPM IT9.21 1996 Life Expectancy of Compact Disks (CD-ROM): This standard provides a method for estimating the life expectancy of compact disks, based on the effects of temperature and relative humidity.

[~~GG.~~] HH. ANSI/PIMA IT9.26 1997 Imaging Materials - Life Expectancy of Magneto-Optic (MO) Disks: This standard provides a method for estimating the life expectancy of magneto-optic disks, based on the effects of temperature and relative humidity.

[~~HH.~~] II. ISO/IEC 1544:2001 Information Technology - Digital compression and coding of continuous-tone still images: Standard for JPEG 2000.

[~~II.~~] JJ. Compuserve, Inc. 1990 GIF Graphics Interchange Format (tm) - A standard defining a mechanism for the storage and transmission of raster-based graphics information, version 89a.

[~~JJ.~~] KK. ISO/IEC 10918-1:1994 Information technology - Digital compression and coding of continuous-tone still images: Requirements and guidelines. This is the basic JPEG standard.

[~~KK.~~] LL. ISO/IEC 10918-2:1995 Information technology - Digital compression and coding of continuous-tone still images: Compliance testing. This provides testing requirements for JPEG formats.

[~~LL.~~] MM. ISO/IEC 10918-3:1997 Information technology - Digital compression and coding of continuous-tone still images: Extensions. This standard provides for extensions on the basic JPEG standard.

[~~MM.~~] NN. ISO/IEC 10918-3:1997/Amd 1:1999 Provisions to allow registration of new compression types and versions in the SPIFF header. This is an extension of the basic JPEG standard.

[~~NN.~~] OO. ISO/IEC 10918-4:1999 Information technology - Digital compression and coding of continuous-tone still images: Registration of JPEG profiles, SPIFF profiles, SPIFF tags, SPIFF colour spaces, APPn markers, SPIFF compression types and Registration Authorities (REGAUT)

[~~OO.~~] PP. ISO 9660:1988 Information Processing - Volume and File Structure of CD-ROM for Information Interchange.

[~~PP.~~] QQ. ISO 9848:1993 Photography — Source Document Microfilms — Determination of ISO Speed and ISO Average Gradient: This international standard ANSI/NAPM specifies a method for determining the ISO speed and ISO average IT2.51-1993 gradient of black-and-white camera negative photographic films used for first generation

microfilming of source document at exposure times typically found with tungsten sources, including any handwritten or printed alphanumeric and line documents such as books, periodicals, business correspondence, and engineering drawings.

[~~QQ.~~] RR. ISO 12639:1998 Graphic Technology - Prepress Digital Data Exchange - Tag Image File Format For Imaging Technology.

[3-29-92, 7-29-96; 1.14.2.17 NMAC - Rn, 1 NMAC 3.2.60.1.12 & A, 12-29-00, A, 06/30/09]

NEW MEXICO STATE RECORDS CENTER AND ARCHIVES

This is an amendment to 1.24.15 NMAC, Sections 12 and 13 effective July 1, 2009.

1.24.15.12 CHARGES FOR PUBLISHING IN THE NEW MEXICO REGISTER: There shall be a [~~$1.50~~] $2.00 per column inch charge to agencies publishing material in the New Mexico register.

[1.24.15.12 NMAC - Rp 1 NMAC 3.3.15.10, 2/29/2000; A, 7/15/2003; A, 7/1/2009]

1.24.15.13 FEES FOR COPIES OF THE NEW MEXICO REGISTER:

A. Individual copies of the New Mexico register shall be $12.00.

B. Annual paper subscription fees for the New Mexico register shall be $270.00.

[~~**C.** Advertising rates for New Mexico register shall be:~~

~~**(1)** single, full page insertion - $150.00;~~

~~**(2)** single, half page insertion - $80.00; and~~

~~**(3)** single, quarter page insertion - $50.00.~~

~~**D.** Electronic copies of the New Mexico register shall be $0.0005 per byte, in full or in part.~~]

[1.24.15.13 NMAC - Rp 1 NMAC 3.3.15.11 & 1 NMAC 3.3.15.12 & 1 NMAC 3.3.15.13 & 1 NMAC 3.3.14, 2/29/2000; A, 7/15/2003; A, 7/1/2009]

End of Adopted Rules Section

Other Material Related to Administrative Law

NEW MEXICO DEPARTMENT OF AGRICULTURE

Public Meeting Notice

A meeting of the Acequia and Community Ditch Fund Committee will be held to determine distribution of the 2009 Acequia and Community Ditch Fund. The meeting will be held on Tuesday, July 21, 2009, at 1:30 p.m. in Santa Fe, New Mexico, Room 326, State Capitol Building.

Copies of the agenda may be obtained by contacting the New Mexico Department of Agriculture, at (505) 646-1091, or by writing New Mexico Department of Agriculture, Agricultural Programs and Resources, MSC-APR, P O Box 30005, Las Cruces, New Mexico 88003-8005.

NOTICE TO PERSONS WITH DISABILITIES: If you have a disability and require special assistance to participate in this meeting, please contact the New Mexico Department of Agriculture at least three (3) days prior to the meeting, at (505) 646-1091. Disabled persons who need documents such as agendas or minutes in accessible form should contact the New Mexico Department of Agriculture.

End of Other Related Material Section

SUBMITTAL DEADLINES AND PUBLICATION DATES

2009

Volume XX	Submittal Deadline	Publication Date
Issue Number 1	January 2	January 15
Issue Number 2	January 16	January 30
Issue Number 3	February 2	February 13
Issue Number 4	February 16	February 27
Issue Number 5	March 2	March 16
Issue Number 6	March 17	March 31
Issue Number 7	April 1	April 15
Issue Number 8	April 16	April 30
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Issue Number 20	October 16	October 30
Issue Number 21	November 2	November 13
Issue Number 22	November 16	December 1
Issue Number 23	December 2	December 15
Issue Number 24	December 16	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.