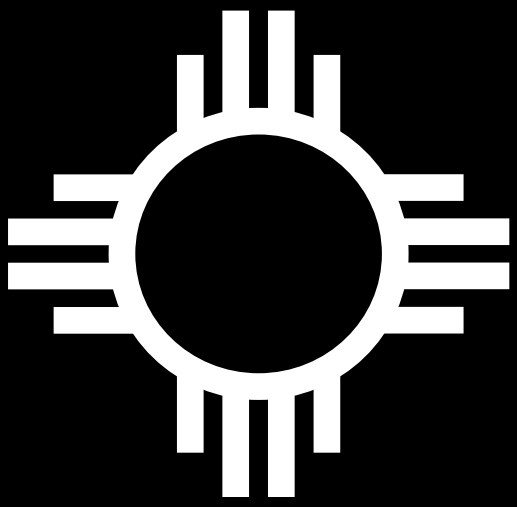
NEW MEXICO REGISTER



Volume XX
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August 31, 2009

New Mexico Register

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

The Commission of Public Records
Administrative Law Division
Santa Fe, New Mexico
2009

New Mexico Register

Volume XX, Number 16
August 31, 2009

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A=*Amended*, E=*Emergency*, N=*New*, R=*Repealed*, Rn=*Renumbered*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

ERRATA NOTICE-CORRECTION OF LOCATION

ALBUQUERQUE-BERNALILLO COUNTY AIR QUALITY CONTROL BOARD
NOTICE OF HEARING

On September 9, 2009, at 5:30 PM, the Albuquerque-Bernalillo County Air Quality Control Board (Air Board) will hold a public hearing in the **City Council Committee Room, 9th Floor, Room 9081** located in the Albuquerque-Bernalillo County Government Center, 400 Marquette Avenue NW, Albuquerque, NM. The hearing will address:

Proposal to repeal the current excess emissions rule, *Breakdown, Abnormal Operating Conditions, Or Scheduled Maintenance*, at Section 20.11.90.12 NMAC, and replace it with a new rule, 20.11.49 NMAC, *Excess Emissions*. There are also cross-references to the current rule found within the *Volatile Organic Compounds* rule at 20.11.65.7.A NMAC and within the *Pathological Waste Destructors* rule at 20.11.69.25.A NMAC which are proposed to be changed to reference the new proposed rule. The AQD is proposing to repeal the current excess emissions rule, *Breakdown, Abnormal Operating Conditions, Or Scheduled Maintenance*, at Section 20.11.90.12 NMAC, and replace it with a new rule, 20.11.49 NMAC, *Excess Emissions.*

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 ENVIRONMENTAL IMPROVEMENT BOARD

NEW MEXICO ENVIRONMENTAL IMPROVEMENT BOARD
NOTICE OF RULEMAKING HEARING

The New Mexico Environmental Improvement Board ("Board") will hold a public hearing on November 3, 2009 at 9:00 a.m. in Room 317 at the State Capitol in Santa Fe, New Mexico. The purpose of the hearing is to consider the matter of EIB 09-09 (R), a petition to adopt proposed new Air Quality Control Regulations 20.2.100 New Mexico Administrative Code (NMAC) (Greenhouse Gas Reporting - General Provisions), 20.2.101 NMAC (Greenhouse Gas Reporting - Verification Requirements), 20.2.102 NMAC (Greenhouse Gas Reporting - General Stationary Combustion), 20.2.103 NMAC (Greenhouse Gas Reporting - Electricity Generation), 20.2.104 NMAC (Greenhouse Gas Reporting - Refineries), 20.2.105 NMAC (Greenhouse Gas Reporting - Petrochemical Manufacturing), 20.2.106 NMAC (Greenhouse Gas Reporting - Cement Production), 20.2.107 NMAC (Greenhouse Gas Reporting - Lime Manufacturing), and 20.2.108 NMAC (Greenhouse Gas Reporting - Coal Storage), and proposed repeal of 20.2.87 NMAC (Greenhouse Gas Emissions Reporting).

The petitioner and proponent of this regulatory adoption and repeal is the New Mexico Environment Department ("NMED").

These proposed new regulations are intended to establish comprehensive, uniform and accurate mandatory reporting of greenhouse gas emissions by facilities, to support future development of a regional cap-and-trade program for greenhouse gases. It is proposed that the existing regulation 20.2.87 NMAC (Greenhouse Gas Emissions Reporting) be repealed because it would be made redundant by adoption of the proposed new regulations.

The proposed revised regulations may be reviewed during regular business hours at the NMED Air Quality Bureau office, 1301 Siler Road, Building B, Santa Fe, New Mexico. Full text of NMED's proposed new rules, and notices of opportunities to get more information on the proposed rules, are available on NMED's web site at www.nmenv.state.nm.us, or by contacting Brad Musick at (505) 476-4321 or brad.musick@state.nm.us.

The hearing will be conducted in accordance with 20.1.1 NMAC (Rulemaking Procedures - Environmental Improvement Board), the Environmental Improvement Act, Section 74-1-9 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 submit relevant evidence, data, views and arguments, orally or in writing, to introduce exhibits, and to examine witnesses. Persons wishing to present technical testimony must file with the Board a written notice of intent to do so. The notice of intent shall:

(1) identify the person for whom the witness(es) will testify;
(2) identify each technical witness that the person intends to present and state the qualifications of the witness, including a description of their education 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) list and describe, or attach, each exhibit anticipated to be offered by that person at the hearing; and
(5) attach the text of any recommended modifications to the proposed new and revised regulations.

Notices of intent for the hearing must be received in the Office of the Board not later than 5:00 pm on October 2, 2009, and should reference the docket number, EIB 09-09 (R), and the date of the hearing. Notices of intent to present technical testimony should be submitted to:

Joyce Medina, Board Administrator
Office of the Environmental Improvement Board
Harold Runnels Building
1190 St. Francis Dr., Room N-2150 / 2153
Santa Fe, NM 87502
Phone: (505) 827-2425, Fax (505) 827-2836

Any member of the general public may testify at the hearing. No prior notification is required to present non-technical testimony at the hearing. Any such member may also offer exhibits in connection with his testimony, so long as the exhibit is not unduly repetitious of the testimony.

A member of the general public who wishes to submit a written statement for the record, in lieu of providing oral testimony at the hearing, shall file the written statement prior

to the hearing, or submit it at the hearing.

Persons having a disability and needing help in being a part of this hearing process should contact Judy Bentley by October 19, 2009 at the NMED, Personnel Services Bureau, P.O. Box 26110, 1190 St. Francis Drive, Santa Fe, New Mexico, 87502, telephone 505-827-9872. TDY users please access her number via the New Mexico Relay Network at 1-800-659-8331.

The Board may make a decision on the proposed revised regulations at the conclusion of the hearing, or the Board may convene a meeting at a later date to consider action on the proposal.

NEW MEXICO ENVIRONMENTAL IMPROVEMENT BOARD

NEW MEXICO ENVIRONMENTAL IMPROVEMENT BOARD
NOTICE OF PUBLIC HEARING TO CONSIDER PROPOSED AMENDMENTS TO 20.7.3.7, 20.7.3.401, 20.7.3.402 AND 20.7.3.904 NMAC.

The New Mexico Environmental Improvement Board (Board) will hold a public hearing beginning at 9:00 a.m. on November 3, 2009, and continuing thereafter as necessary at the New Mexico State Capitol Building, Room 317, 490 Old Santa Fe Trail, Santa Fe, New Mexico. The hearing location may change prior to November 3, and those interested in attending should check the EIB website: http://www.nmenv.state.nm.us/oots/eib.htm prior to the hearing. The purpose of the hearing is to consider proposed amendments to Liquid Waste Disposal Rules, 20.7.3.7, 20.7.3.401, 20.3.1.402 AND 20.3.1.904 NMAC. The New Mexico Environment Department (NMED) is the proponent of the amendments to the rules. In addition, amendments to 20.7.3.904 have been proposed by the Professional On-Site Wastewater Re-use Association of New Mexico, Inc., and Mr. Link Summers.

The amendments proposed by NMED to 20.7.3.904 NMAC would remove the certification requirements for on-site liquid waste system installers, other than the requirement that installers hold a valid and appropriate classification of contractors license from the New Mexico Construction Industries Division. The proposed amendments would also remove the classifications of site evaluator, system designer, wastewater reuse irrigator and septage pumper from the certification requirement of 20.7.3.904 NMAC. The proposed amendments to Section 904 would also eliminate the Education Steering Committee. Besides amendments of 20.7.3.904, the Department seeks amendment of 20.7.3.7 NMAC (Definitions), 20.7.3.401 NMAC (Permitting; General requirements), and 20.7.3.402 NMAC (Permitting, Conventional Treatment and Disposal Systems), for the purpose of making these sections consistent with the proposed amendments to 20.7.3.904 NMAC.

Amendments proposed to 20.3.3.904 NMAC by the Professional On-Site Wastewater Re-use Association of New Mexico, Inc. and Mr. Link Summers would assign the duty of adopting, developing administering and implementing the certification program to the Utility Operator Certification Program, would eliminate the classifications of Installer 1 and 2, would add a classification of "consultant", and would eliminate the Education Steering Committee.

Please note that formatting and minor technical changes in the regulations other than those proposed by petitioners may occur. In addition, the Board may make other changes as necessary to accomplish the purpose of providing public health and safety in response to public comments and evidence presented at the hearing.

The proposed changes may be reviewed during regular business hours at the office of the Environmental Improvement Board located in the Harold Runnels Building, 1190 St. Francis Drive, Room N-2153 Santa Fe, NM, 87505. In addition, a copy of the NMED proposed amendments is posted on the NMED website at http://www.nmenv.state.nm.us/fod/LiquidWaste/documents/june26.2009.petition.PDF, and a copy of the amendments proposed by the Professional On-Site Wastewater Re-use Association of New Mexico, Inc., and Mr. Link Summers is at http://www.nmenv.state.nm.us/fod/LiquidWaste/documents/POWRASummerspetition090730.pdf .

Written comments regarding the proposed revisions may be addressed to Ms. Joyce Medina at the above address, and should reference docket number EIB 09-08R.

The hearing will be conducted in accordance with 20.1.1 NMAC (Rulemaking Procedures) Environmental Improvement Board, the Environmental Improvement Act, Section 74-1-9 NMSA 1978, and other applicable procedures.

All interested persons will be given reasonable opportunity at the hearing to submit relevant evidence, data, views and arguments, orally or in writing, to introduce exhibits, and to examine witnesses. Any person who wishes to submit a non-technical written statement for the record in lieu of oral testimony must file such statement prior to the close of the hearing.

Persons wishing to present technical testimony must file with the Board a written notice of intent to do so on or before 5:00 pm on October 19, 2009. The notice of intent shall:

- identify the person or entity for whom the witness(es) will testify;
- identify each technical witness that the person intends to present and state the qualifications of the witness, including a description of his or her education and work background;
- summarize or include a copy of the direct testimony of each technical witness and state the anticipated duration of the testimony of that witness;
- list and describe, or attach, each exhibit anticipated to be offered by that person at the hearing, including any proposed statement of reasons for adoption of the rules; and,
- attach the text of any recommended modifications to the proposed changes.

Notices of intent for the hearing must be received in the Office of the Environmental Improvement Board not later than 5:00 pm on October 19, 2009, and should reference the name of the regulation, the date of the hearing, and docket number EIB 09-08 (R). Notices of intent to present technical testimony should be submitted to:

Joyce Medina
Office of the Environmental Improvement Board
Harold Runnels Building
1190 St. Francis Dr., Room N-2153
Santa Fe, NM 87502

If you are an individual with a disability and you require assistance or an auxiliary aid, e.g. sign language interpreter, to participate in any aspect of this process, please contact the Personnel Services Bureau by October 19, 2009. The Personnel Services Bureau can be reached at the New Mexico Environment Department, 1190 St. Francis Drive, P.O. Box 26110, Santa Fe, NM 87502, (505) 827-9872. TDD or TDY users may access this number via the New Mexico Relay Network (Albuquerque TDD users: (505) 275-7333; outside of Albuquerque: 1-800-659-1779.)

The Board may make a decision on the proposed regulatory change at the conclusion of the hearing, or the Board may convene a meeting after the hearing to consider action on the proposal.

NEW MEXICO GAMING CONTROL BOARD

NEW MEXICO GAMING CONTROL BOARD

NOTICE OF HEARING ON AMENDMENTS TO RULES

The New Mexico Gaming Control Board ("Board") will hold a public hearing at 10:00 a.m. on October 7, 2009, at the New Mexico Gaming Control Board, 4900 Alameda Blvd., N.E., Albuquerque, New Mexico 87113 to consider amendments for the following rules: **15.1.5 NMAC,** *Application for Licensure Under the Gaming Control Act,* **15.1.7 NMAC,** *Gaming Machines, New Games and Associated Equipment,* **15.1.8 NMAC,** *Accounting Requirements under the Gaming Control Act,* **15.1.9 NMAC,** *Internal Control Minimum Standards for Gaming Devices under the Gaming Control Act,* **15.1.10 NMAC,** *Conduct of Gaming under the Gaming Control Act,* **15.1.13 NMAC,** *License and Certification Renewal Requirements under the Gaming Control Act,* **15.1.16 NMAC,** *Transportation, Receipt, and Placement of Gaming Devices,* **15.1.17 NMAC,** *Schedule of Violations under the Gaming Control Act Which Penalties Could Be Assessed,* **15.1.24 NMAC,** *Progressive Games and Gaming Devices*

Copies of the proposed amendments are available on request to the New Mexico Gaming Control Board, 4900 Alameda Blvd., N.E., Albuquerque, New Mexico 87113, or by calling (505) 841-9733. The proposed changes are also available on our website at www.nmgcb.org. The Board can provide public documents in various accessible formats.

The hearing will be held before a hearing officer appointed by the Board. All interested parties may attend the hearing and present their views orally or submit written comments prior to the hearing. Written comments should be directed to the Gaming Control Board, 4900 Alameda Blvd., N.E., Albuquerque, New Mexico 87113.

If you are an individual with a disability who is in need of an auxiliary aid or service to attend or participate in the hearing, please contact Denise Leyba, Gaming Control Board, at least one week prior to the hearing at (505) 841-9733.

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

NOTICE

The New Mexico Human Services Department (HSD) will hold a public hearing at 9:00 a.m., on September 15, 2009, in the HSD Law Library at Pollon Plaza, 2009 S. Pacheco Street, Santa Fe, New Mexico. The subject of the hearing will be Discontinuation of 5 Year Bar for Pregnant Women and Children and 12 Months Continuous Eligibility.

To qualify for the performance bonus payments under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), the Human Services Department (HSD) is proposing to make eligibility for Children's Medicaid (Category 032 only) 12 months continuous regardless of changes in income. Changes other than the recipient's death or a move out-of-state will not need to be reported during the 12-month certification period. This bonus payment is necessary to help New Mexico defray the cost of enrolling more uninsured children who are already eligible for Medicaid.

CHIPRA 2009 also gave states a new option to provide Medicaid and CHIP coverage to lawfully residing immigrant children and pregnant women during the 5-year bar imposed by earlier Personal Responsibility of Work Opportunity Reconciliation Act (PRWORA) legislation. HSD is proposing to allow Medicaid coverage for pregnant women and children who otherwise meet the eligibility criteria for categories of eligibility 031, 032, 35 and 072, but who have not been in legal permanent resident status for the full 5 years.

Interested persons may submit written comments no later than 5:00 p.m., September 15, 2009, to Pamela S. Hyde, J.D., Secretary, Human Services Department, PO Box 2348, Santa Fe, New Mexico 87504-2348. All written and oral testimony will be considered prior to issuance of the final regulation.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in any HSD public hearing, program or services, please contact the NM Human Services Department toll-free at 1-888-997-2583, in Santa Fe at 827-3156, or through the department TDD system, 1-800-609-4833, in Santa Fe call 827-3184. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations.

Copies of the Human Services Register are available for review on our Website at www.hsd.state.nm.us/mad/registers by sending a self-addressed stamped envelope to Medical Assistance Division, Program Oversight & Support Bureau, PO Box 2348, Santa Fe, NM. 87504-2348.

NEW MEXICO MINING SAFETY BOARD

New Mexico Mining Safety Board

Notice of Public Meeting and Hearing of the New Mexico Mining Safety Board

The New Mexico Mining Safety Board will hold a public meeting beginning at 10:00 a.m. **Friday, October 2, 2009** in the conference room of the Workers' Compensation Administration 2410 Centre Ave. SE, Albuquerque, NM 87125-7198.

During the meeting, the Mining Safety Board will conduct a public hearing on proposed rules for mining safety proposed by the Mining Safety Board. The Board will consider comment regarding rules for the penalty structure for failure to report an accident. To view proposed rules, go to the State Mine Inspector's homepage at http:\\www.nmminesafety.com . Copies of the proposed rule changes are also available from the New Mexico Bureau of Mine Safety, 801 Leroy Place, Socorro, NM 87801 or by calling 575-835-5460. At the conclusion of the hearing, the Mining Safety Board may deliberate and vote on the proposed rule changes.

A copy of the agenda for the meeting/hearing will be available at least 24 hours before the meeting and may be obtained by contacting the State Mine Inspector, Terence Foreback at 575-835-5460. If you need a reader, amplifier, qualified sign language interpreter or any other form of auxiliary aid or service to attend or participate in the hearing, please contact Terence Foreback at least 48 hours prior to the hearing. Public documents can be provided in various accessible forms. Please contact Terence Foreback if a summary or other type of accessible form is needed.

NEW MEXICO COMMISSIONER OF PUBLIC LANDS

NOTICE OF RULE MAKING

NOTICE IS HEREBY GIVEN that Patrick H. Lyons, New Mexico Commissioner of Public Lands (Commissioner), and the New Mexico State Land Office (NMSLO) propose to amend 19.2.8 NMAC "RELATING TO AGRICULTURAL LEASES, which incorporates various changes, amendments, additions to and deletions from the previous rule.

The proposed new rule provides new and/or amended guidelines and requirements that pertain to all agricultural leases on lands held in the Trust managed by the New Mexico Commissioner of Public Lands pursuant to the Act of June 20, 1910, 36 Stat. 557, Chapter 310; N.M. Const. Art. XIII; and NMSA 1978, Chapter 19.

The Commissioner will take written comments on the proposed rule from any interested person. Interested persons shall file their written comments no later than October 5, 2009. Comments suggesting changes to the proposed rule shall state and discuss the particular reasons for the suggested changes and shall include specific language proposed to effectuate the changes being suggested. Specific proposed language changes to the proposed new rule should, whenever possible, be in the same format that the proposed rule is in. A copy of the proposed rule in electronic format may be obtained from the Commissioner to facilitate this requirement. Any proposed changes to the proposed rule shall be submitted either in hard copy or by e-mail. The Commissioner strongly encourages all persons submitting comments in hard copy to file an additional copy in electronic format. The electronic medium shall clearly designate the name of the person submitting the proposed changes.

One public hearing to receive oral and written comments on proposed amendments to Rule 8 will be held in Santa Fe, New Mexico, at Morgan Hall, State Land Office, 310 Old Santa Fe Trail, from 9:00 a.m. to 11:00 a.m. on Friday, October 2nd, 2009.

Please submit any written comments regarding the proposed rule to the attention of Ley Schimoler at the address set forth below and/or by e-mail to Ley Schimoler at lschimoler@slo.state.nm.us. Comments received by e-mail will be printed by the NMSLO and entered in the rule-making record.

The Commissioner will review and take into consideration all timely submitted written comments. If the Commissioner deems it advisable, he may have further meetings with any persons or entities submitting written comments.

A copy of the proposed rule may be obtained from:
Ley Schimoler
Office of the General Counsel
New Mexico State Land Office
PO Box 1148
Santa Fe, NM 87504-1148
Tel: 505/827-5713
Fax: 505/827-4262

Copies of the proposed rule may also be viewed at, or downloaded from the NMSLO website (www.nmstatelands.org). Upon request the documents may be made available in alternative formats.

NEW MEXICO REGULATION AND LICENSING DEPARTMENT

MANUFACTURED HOUSING DIVISION

Regulation and Licensing Department - Manufactured Housing Division
LEGAL NOTIFICATION OF PUBLIC HEARING

The Regulation and Licensing Department, Manufactured Housing Division, ("Division") hereby gives notice that the Division will conduct a public hearing to consider adopting amendments to New Mexico Administrative Code, Part 14.12.2 NMAC, Manufactured Housing.

The Hearing will be held at the Toney Anaya Building located at 2550 Cerrillos Road, Hearing Room 2, 2nd Floor, Santa Fe, New Mexico 87505 on Tuesday, October 20, 2009 and will begin at 9:00 a.m.

Copies of the proposed rules are available on the Manufactured Housing Division Website: www.rld.state.nm.us/MHD/index.htm or by sending a request to the Manufactured Housing Division, P.O. Box 25101, Santa Fe, New Mexico 87504. Phone (505) 476-4770.

The public is invited to attend and comment on the proposed amendments. Members of the Manufactured Housing Committee will serve as the Hearing Officer and will receive oral and written recommendations and comments regarding the proposed amendments. Written recommendations and comments, including draft language, may be submitted to the Division in advance of the meeting at the address provided below. These recommendations/comments must be provided no later than October 13, 2009, 5:00 p.m. in order to be included in the materials for the public hearing. All other recommendations/comments must be presented at the October 20, 2009 hearing.

Following the Public Hearing, the State of New Mexico Manufactured Housing Committee will convene a Regular Committee Meeting on Tuesday, October 20, 2009 immediately following the public hearing. The public is welcome to attend. Persons desiring to present their views may appear in person or send their written comments to the Manufactured Housing Division office at P.O. Box 25101, Santa Fe, New Mexico 87504.

The Committee may go into closed session during the meeting to discuss issues pertaining to issuance, suspension, renewal or revocation of a license or limited personnel matters as permitted by the Open Meetings Act. A final agenda for the meeting will be available at least 24 hours prior to the meeting and may be obtained by making a written, verbal or faxed request to the Manufactured Housing Division, P.O. Box 25101, Santa Fe, New Mexico 87504. Phone (505) 476-4770 or Fax: (505) 476-4702.

If you are an individual with a disability who is in need of a reader, amplifier, qualified sign language interpreter, or any other for of auxiliary aid or service to attend or participate in the meeting, please contact the Manufactured Housing Division office at (505) 476-4770, prior to the meeting but not later than October 16, 2009. Public documents, including the agenda and minutes, can be provided in various accessible formats.

Wayne Dotson, Director
Manufactured Housing Division
P.O. Box 25101
Santa Fe, New Mexico 87504

NEW MEXICO RETIREE HEALTH CARE AUTHORITY

NEW MEXICO RETIREE HEALTH CARE AUTHORITY
NOTICE OF PUBLIC HEARING ON PROPOSED RULE CHANGES

The New Mexico Retiree Health Care Authority will hold a public hearing on proposed changes to its rules concerning Contracts for Purchase of Professional Services, 2.81.4 NMAC and concerning benefits for domestic partners, amending 2.81.5 through 2.81.9 NMAC.

The hearing will be held at:

New Mexico Retiree Health Care Authority
4308 Carlisle NE
Myo Rehab Conference Room, Suite 208
Albuquerque, New Mexico 87107
Monday, SEPTEMBER 14, 2009
9:30 a.m.

Copies of the proposed rule changes may be obtained on the New Mexico Retiree Health Care Authority website www.nmrhca.state.nm.us or by contacting Ramona Martinez at (505) 222 6420.

Comments on the proposed rule changes may be submitted in writing to Ramona Martinez, New Mexico Retiree Health Care Authority, 4308 Carlisle Blvd. NE, Suite 104, Albuquerque, NM 87107 by 5:00 p.m., September 14, 2009 or presented orally at the hearing.

If any interested person has a disability and is in need of a reader, amplifier, qualified sign language interpreter or any other form of auxiliary aid or service in order to attend or participate in the hearing, please contact Ramona Martinez, five days prior to the meeting.

End of Notices and Proposed Rules Section

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Adopted Rules

ALBUQUERQUE-BERNALILLO COUNTY AIR QUALITY CONTROL BOARD

This is an amendment to 20.11.1 NMAC, Sections 1, 2, 3, 5, 6, 7, 9, 10, 11 and 14, effective 9/14/2009.

20.11.1.1 ISSUING AGENCY: Albuquerque - Bernalillo County Air Quality Control Board. P.O. Box 1293, Albuquerque, NM 87103. Telephone: (505) [~~768-2600~~] 768-2601.
[6/14/71. . .12/1/95; 20.11.1.1 NMAC - Rn, 20 NMAC 11.01.I.1, 10/1/02; A, 9/14/09]

20.11.1.2 SCOPE:

A. [~~This part~~] 20.11.1 NMAC is applicable [~~to the city of Albuquerque and~~] within Bernalillo county.

B. Exempt: [~~This part~~] 20.11.1 NMAC does not apply to sources within Bernalillo county, which are located on Indian lands over which the Albuquerque - Bernalillo county air quality control board lacks jurisdiction.
[12/1/95. . .8/1/96; 20.11.1.2 NMAC - Rn, 20 NMAC 11.01.I.2, 10/1/02; A, 9/14/09]

20.11.1.3 STATUTORY AUTHORITY: [~~This part~~] 20.11.1 NMAC is adopted pursuant to the authority provided in the New Mexico Air Quality Control Act, NMSA 1978 Sections 74-2-4, 74-2-5.C; the Joint Air Quality Control Board Ordinance, Bernalillo County Ordinance 94-5 Sections 3 & 4; the Joint Air Quality Control Board Ordinance, Revised Ordinances of Albuquerque 1994 Sections 9-5-1-3 & 9-5-1-4.
[6/14/71. . .12/1/95; 20.11.1.3 NMAC - Rn, 20 NMAC 11.01.I.3, 10/1/02; A, 7/1/04; A, 9/14/09]

20.11.1.5 EFFECTIVE DATE: [~~The effective date of Part 1 is,~~] December 1, 1995, unless a later date is cited at the end of a section. The effective date of a specific section is located at the end of that section within the historical brackets. As required by the New Mexico Air Quality Control Act, Chapter 74, Article 2, Section 6 NMSA 1978, no regulation or emission control requirement or amendment thereto, or repeal thereof, shall become effective until 30 days after its filing under the State Rules Act, Chapter 14, Article 4 NMSA 1978.
[12/1/95. . .8/1/96; 20.11.1.5 NMAC - Rn, 20 NMAC 11.01.I.5 & A, 10/1/02; A, 12/1/03; A, 7/1/04; A, 9/14/09]

20.11.1.6 OBJECTIVE: [~~The objective of this part is~~] To provide definitions which are generally applicable to Albuquerque - Bernalillo county air quality control board regulations.
[12/1/95; 20.11.1.6 NMAC - Rn, 20 NMAC 11.01.I.6 & A, 10/1/02; A, 7/1/04; A, 9/14/09]

20.11.1.7 DEFINITIONS: The definitions of [~~This part~~] 20.11.1 NMAC apply unless there is a conflict between definitions in other parts, in which case the definition found in the applicable part shall govern. The definitions include the measurements, abbreviations, and acronyms in Subsection GGGG, of 20.11.1.7 NMAC.

A. "Abnormal operating conditions" means the startup or shutdown of air pollution control device(s) or process equipment.

B. "Administrator" means the administrator of the United States environmental protection agency or his or her designee.

C. "Affected source" or "facility" means any stationary source, or any other source of air pollutants, that must comply with an applicable requirement.

D. "Air agency", "department" or "EHD" means the environmental health department (EHD) of the city of Albuquerque. The EHD, or its successor agency or authority, as represented by the department director or his/her designee, is the lead air quality planning agency for the Albuquerque - Bernalillo county nonattainment/maintenance area. The EHD serves as staff to the Albuquerque - Bernalillo county air quality control board, (A-BC AQCB), and is responsible for the administration and enforcement of the A-BC AQCB regulations.

E. "Air contaminant" or "air pollutant" means an air pollution agent or combination of such agents, including any physical, chemical, biological, radioactive (including source material, special nuclear material, and byproduct material) substance or matter which is emitted into or otherwise enters the ambient air. Such term includes any precursors to the formation of any air pollutant; to the extent the EPA has identified such precursor or precursors for the purpose for which the term "air pollutant" is used. This excludes water vapor, nitrogen (N_2), carbon dioxide (CO_2), oxygen (O_2), methane and ethane.

F. "Air pollution" means the emission, except as such emission occurs in nature, into the outdoor atmosphere of one or more air contaminants in such quantities and duration as may with reasonable probability injure human health, animal or plant life, or as may unreasonably interfere with the public welfare, visibility or the reasonable use of property.

G. "Air quality control act" means the State of New Mexico Air Quality Control Act, Chapter 74, Article 2, NMSA 1978 as amended.

H. "Air quality control board", "board" or "A-BC AQCB" means the Albuquerque - Bernalillo county air quality control board, which is empowered by federal act, the Air Quality Control Act, and ordinances, to prevent or abate air pollution within the boundaries of Bernalillo county, except for Indian lands over which the board lacks jurisdiction.

I. "Allowable emissions" means:

(1) Any department or federally enforceable permit term or condition which limits the quantity, rate, or concentration of emissions of air pollutants on a continuous basis, including any requirements which limits the level of opacity, prescribe equipment, set fuel specifications, or prescribe operation or maintenance procedures for a source to assure continuous reduction that are requested by the applicant and approved by the department or, determined at the time of issuance or renewal of a permit to be an applicable requirement.

(2) Any federally enforceable emissions cap that the permittee has assumed to avoid an applicable requirement to which the source would otherwise be subject.

J. "Ambient" means that portion of the atmosphere, external to buildings, to which the general public has access.

K. "Applicable requirement" means any of the following (and includes requirements that have been promulgated or approved by the board or EPA through rulemaking):

(1) any standard or other requirement provided for in the New Mexico state implementation plan approved by EPA, or promulgated by EPA through rulemaking, under Title I, including Parts C or D, of the federal act;

(2) any term or condition of any pre-construction permit issued pursuant to regulations approved or promulgated through rulemaking under Title I, including parts C or D, of the federal act;

(3) any standard or other requirement:

(a) under Section 111 or 112 of the federal act;

(b) of the acid rain program under Title IV of the federal act or the regulations promulgated thereunder;

(c) governing solid waste incineration under Section 129 of the federal act;

(d) for consumer and commercial products under Section 183(e) of the federal act;

(e) of the regulations promulgated to protect stratospheric ozone under Title VI of the federal act, unless the administrator has determined that such requirements need not be contained in a Title V permit;

(4) any requirements established pursuant to Section 504(b) or Section 114(a)(3) of the federal act;

(5) any national or state ambient air quality standard;

(6) any increment or visibility requirement under Part C of Title I of the federal act applicable to temporary sources permitted pursuant to Section 504(e) of the federal act;

(7) any regulation adopted by the board in accordance with the joint air quality control board ordinances pursuant to the Air Quality Control Act, and the laws and regulations in effect pursuant to the Air Quality Control Act.

L. "Breakdown [~~, malfunction~~] or upset" means any sudden, infrequent, and not reasonably preventable failure of air pollution control equipment, or process equipment, which causes a process to not operate in a normal manner. Failures that are caused by process imbalance, poor maintenance or careless operation are not breakdowns.

M. "Carbon monoxide" or "CO" means a colorless, odorless, poisonous gas composed of molecules containing a single atom of carbon and a single atom of oxygen with a molecular weight of 28.01 g/mole.

N. "Chemical process" means any manufacturing processing operation in which one or more changes in chemical composition or chemical properties are involved.

O. "Coal burning equipment" means any device used for the burning of coal for the primary purpose of producing heat or power by indirect heat transfer in which the products of combustion do not come into direct contact with other materials.

P. "Commenced" means that an owner or operator has undertaken a continuous program of construction or that an owner or operator has entered into a binding agreement or contractual obligation to undertake and complete, within a reasonable time, a continuous program of construction or modification.

Q. "Construction" means fabrication, erection, or installation of an affected facility.

R. "Crematory" means any combustion unit designed and used solely for cremating human or animal remains or parts and tissues thereof, and other items normally associated with the cremation process, but not including pathological waste.

S. "Department" means the Albuquerque environmental health department, which is the administrative agency of the Albuquerque - Bernalillo county air quality control board.

T. "Director" means the administrative head of the Albuquerque environmental health department or a designated representative(s).

U. "Emission limitation or standard" means a requirement established by EPA, the state implementation plan (SIP), the Air Quality Control Act, local ordinance, permit, or board [~~part or~~] regulation, that limits the quantity, rate or concentration, or combination thereof, of emissions of regulated air pollutants on a continuous basis, including any requirements relating to the operation or maintenance of a source to assure continuous reduction.

V. "EPA" means the United States environmental protection agency or the EPA's duly authorized representative.

W. "Excess emissions" means [~~emissions of an air pollutant in excess of an emission limit or standard.~~] the emission of an air contaminant, including a fugitive emission, in excess of the quantity, rate, opacity or concentration specified by an air quality regulation or permit condition.

X. "Excess emissions report" means a report submitted by a stationary source at the request of the department in order to provide data on the source's compliance with emission limits and operating parameters.

Y. "Federal act", "act" or "CAA" means the Federal Clean Air Act, 42 U.S.C. Section 7401 through 7671 et seq., as amended.

Z. "Federal class I wilderness areas" means areas designated by the EPA as such. Federal class I wilderness areas within 100 kilometers of Bernalillo county are Bandelier wilderness, Pecos wilderness, and San Pedro Parks wilderness.

AA. "Fluid" means either of the two states of matter, liquid or gaseous.

BB. "Fugitive emissions" means any emissions which cannot reasonably pass through a stack, chimney, vent, or other functionally-equivalent opening or is not otherwise collected, unless the emission is otherwise regulated by the federal act, the Air Quality Control Act, or the laws and regulation in effect pursuant to the act.

CC. "Grain" means that unit of weight, which is equivalent to 0.0648 grams.

DD. "Hazardous air pollutant" means an air contaminant which has been classified pursuant to the federal act, the Air Quality Control Act, or laws and regulations in effect pursuant to the act.

EE. "Hydrocarbons" or "HC" means any chemical compound of a class of aliphatic, cyclic, or aromatic chemical compounds containing mostly hydrogen and carbon. Hydrocarbons are highly reactive in the presence of nitrogen oxides and sunlight. All are precursors to more serious air pollutants such as ozone and nitrogen dioxide.

FF. "Hydrogen sulfide" or "H_2S" means the chemical compound containing two atoms of hydrogen and one of sulfur with a molecular weight of 34.07 g/mole.

GG. "Incinerator" means any furnace used in the process of burning solid waste for the purpose of reducing the volume, by removing combustible matter.

HH. "Inedible animal by-product processing" means operations primarily engaged in rendering, cooking, drying, dehydration, digesting, evaporating [~~and/or~~] or concentrating of animal proteins and fats.

II. "Kraft mill" means any pulping process, which uses an alkaline solution for a cooking liquor.

JJ. "Lead" or "Pb" means a heavy metal, with a molecular weight of 207.19 g/mole that is hazardous to health if breathed or swallowed.

KK. "Malfunction" means any sudden and unavoidable failure of air pollution control equipment or process equipment beyond the control of the owner or operator, including malfunction during startup or shutdown. A failure that is caused entirely or in part by poor maintenance, careless operation, or any other preventable equipment breakdown shall not be considered a malfunction.

[~~KK~~]LL. "Modification" means any~~-~~physical change in or change in the method of operation of a [~~stationary~~] source [~~which increases~~] that results in an increase in the potential [~~to emit~~] emission rate of any regulated air contaminant emitted by the [~~stationary~~] source or [~~which~~] that results in the emission of any regulated air contaminant not previously emitted, but does not include:

(1) a change in ownership of the source;

(2) routine maintenance, repair or replacement;

(3) installation of air pollution control equipment, and all related process equipment and materials necessary for its operation, undertaken for the purpose of complying with regulations adopted by the environmental improvement board or the local board or pursuant to the federal act; or

(4) unless previously limited by enforceable permit conditions:

(a) an increase in the production rate, if such increase does not exceed the

operating design capacity of the source;

(b) an increase in the hours of operation; or

(c) use of an alternative fuel or raw material if, prior to January 6, 1975, the source was capable of accommodating such fuel or raw material, or if use of an alternate fuel or raw material is caused by any natural gas curtailment or emergency allocation or any other lack of supply of natural gas.

[~~LL~~]MM. "New source" means any stationary source, the construction or modification of which is commenced after the filing of a regulation applicable to the stationary source.

[~~MM~~]NN. "Nitrogen dioxide" or "NO_2" means a reddish brown, poisonous gas composed of molecules containing a single atom of nitrogen and two of oxygen with a molecular weight of 46.0 g/mole.

[~~NN~~]OO. "Nitrogen oxides or NO_x" is a class of chemicals containing varying quantities of nitrogen and oxygen that are created from combustion processes taking place at high temperatures and high pressures (e.g., inside automotive engine cylinders or in high temperature boilers). Examples of nitrogen oxides are NO, NO_2, NO_3, N_2O_2, and N_2O_5. Nitrogen oxides are also referred to as oxides of nitrogen.

[~~OO~~]PP. "NMAC" means New Mexico administrative code, which contains the rules adopted by all rulemaking agencies of the state of New Mexico and the rules adopted by the A-BC AQCB.

[~~PP~~]QQ. "Open burning" means the combustion of any material without the following characteristics:

(1) control of combustion air to maintain adequate temperature for efficient combustion;

(2) containment of the combustion reaction in an enclosed device to provide sufficient residence time and mixing for complete combustion; and

(3) emission controls for the gaseous combustion products.

[~~QQ~~]RR. "Operator" means the person(s) responsible for the overall operation of a source.

[~~RR~~]SS. "Owner" means the person(s) who owns a source or part of a source.

[~~SS~~]TT. "Ozone or O_3" means a pungent, colorless gas composed of molecules containing three atoms of oxygen with a molecular weight of 48.0 g/mole.

[~~TT~~]UU. "Part" means [~~the regulation number in the NMAC~~] the required NMAC designation for the normal division of a chapter. A part consists of a unified body of rule material applying to a specific function or devoted to a specific subject matter. Structurally, a part is the equivalent of a rule.

[~~UU~~]VV. "Particulate matter" or "PM" means any airborne finely divided solid or liquid material such as dust, smoke, mist, fumes or smog found in air or emissions.

[~~VV~~]WW. "Particulate matter emissions" means all finely divided solid or liquid material, other than uncombined water, emitted to the ambient air as measured by the reference method in 40 CFR 60, Appendix A, Method 5, or an equivalent method approved by the EPA.

[~~WW. [Reserved]~~]

XX. "Pathological waste destructor" means any equipment, which is used to dispose of pathological waste by combustion or other process, which is approved by EPA.

YY. "Performance test" means the data, which is the result of a test performed as required by the department to determine compliance.

ZZ. "Permit" means any permit or group of permits, modifications, renewals or revisions authorizing the construction or operation of a stationary source pursuant to the federal act, the Air Quality Control Act, or laws and regulations in effect pursuant to the act.

AAA. "Permittee" means the owner or operator identified in any permit application or permit.

BBB. "Person" means any individual, partnership, firm, public or private corporation, association, trust, estate, political subdivision or agency, or any other legal entity or their legal representatives, agents or assigns.

CCC. "Photochemical oxidants" means an air pollutant, which is formed by the action of sunlight on oxides of nitrogen and hydrocarbons.

DDD. "PM_{10}", "$PM_{2.5}$" or "PM_1" means particulate matter with an aerodynamic diameter less than or equal to 10, 2.5, or 1 micrometers, respectively.

EEE. "$PM_{2.5}$ emissions" means finely divided solid or liquid material with an aerodynamic diameter less than or equal to a nominal 2.5 micrometers emitted into the ambient air as measured by the reference method in 40 CFR Part 50, Appendix L, approved by the EPA.

FFF. "PM_{10} emissions" means finely divided solid or liquid material with an aerodynamic diameter less than or equal to a nominal 10 micrometers emitted into the ambient air as measured by the reference method in 40 CFR Part 50, Appendix J and M, or equivalent method approved by the EPA

GGG. "Pollution control device" or "air pollution control equipment" means any device, equipment, process or combination thereof, the operation of which may limit, capture, reduce, confine, or otherwise control regulated air pollutants or convert for the purposes of control any regulated air pollutant to another form, another chemical or another physical state. This includes, but is not limited to, sulfur recovery units, acid plants, baghouses, precipitators, scrubbers, cyclones, water sprays, enclosures, catalytic converters, and steam or water injection.

HHH. "Portable stationary source" or "temporary stationary source" means a stationary source capable of changing its location with limited dismantling or reassembly which is associated with a specific construction project or increased production demand.

III. "Potential to emit" or "pre-controlled emission rate" means the maximum capacity of a stationary source to emit any air contaminant under its physical and operational design. Any physical or operational limitation on the capacity of a source to emit an air pollutant, including air pollution control equipment and restrictions on hours of operation or on the type or amount of material combusted, stored, or processed, shall be treated as part of its design if the limitation is federally enforceable or is included in a permit issued by the department. However, the potential to emit for nitrogen dioxide shall be based on total oxides of nitrogen.

JJJ. "Process equipment" means any equipment used for storing, handling, transporting, processing or changing any materials whatsoever but excluding that equipment specifically defined in these regulations as incinerators, crematories, pathological waste destructors, pathological destructors and medical waste destructors.

KKK. "Process weight" means the total weight of all materials introduced into any specific process, which causes any discharge of air contaminants into the atmosphere. Solid fuels introduced into any specific process will be considered as part of the process weight, but liquid and gaseous fuels and combustion air will not.

LLL. "Process weight rate" means the hourly rate derived by dividing the total process weight by the number of hours in one complete operation from the beginning of any given process to the completion thereof, or from the beginning to the completion of a typical portion thereof, excluding any time during which the equipment is idle.

MMM. [Reserved]

NNN. "Regulated air pollutant" means the following:

(1) any pollutant for which a national, state, or local ambient air quality standard has been promulgated;

(2) any pollutant that is subject to any standard promulgated under Section 111 of the federal act;

(3) any Class I or II substance subject to any standard promulgated under

or established by Title VI of the federal act; or

(4) any pollutant subject to a standard promulgated under Section 112 or any other requirements established under Section 112 of the federal act.

OOO. "Responsible official" means one of the following:

(1) **for a corporation:** a president, secretary, treasurer, or vice-president of the corporation in charge of a principal business function, or any other person who performs similar policy or decision-making functions for the corporation, or a duly authorized representative of such person if the representative is responsible for the overall operation of one or more manufacturing, production, or operating facilities applying for, or subject to a permit and either:

(a) the facilities employ more than 250 persons or have gross annual sales or expenditures exceeding $25 million (in second quarter 1980 dollars); or

(b) the delegation of authority to such representatives is approved in advance by the department;

(2) **for a partnership or sole proprietorship:** a general partner or the proprietor, respectively;

(3) **for a municipality, state, federal or other public agency:** either a principal executive officer or ranking elected official; for the purposes of [~~this regulation~~] 20.11.1 NMAC, a principal executive officer of a federal agency includes the chief executive officer having responsibility for the overall operations of a principal geographic unit of the agency (e.g., a regional administrator of EPA); or

(4) **for an acid rain source:**

(a) the designated representative (as defined in Section 402(26) of the federal act) in so far as actions, standards, requirements, or prohibitions under Title IV of the federal act or the regulations promulgated thereunder are concerned; and

(b) the designated representative for any other purposes under 40 CFR Part 70.

PPP. "Shutdown" means the cessation of operation of any air pollution control equipment, or process equipment [~~or process for any purpose~~].

QQQ. [Reserved]

RRR. [Reserved]

SSS. "Smoke" means small gas-borne particles resulting from incomplete combustion, consisting predominantly, but not exclusively, of carbon, soot and combustible material.

TTT. "Solid waste" means garbage; refuse; yard waste; food wastes; plastics; leather; rubber; sludge; and other discarded combustible or noncombustible waste, including solid, liquid, semisolid; or contained gaseous material resulting from industrial, commercial, mining, and agricultural operations, and from community or residential activities, and from waste treatment plants, water supply treatment plants, or air pollution control facilities; but does not include solid or dissolved material in domestic sewage, or solid or dissolved materials in irrigation return flows or industrial discharges which are point sources subject to permit under Section 402 of the Federal Water Pollution Control Act, or source, special nuclear, or byproduct material as defined by the Atomic Energy Act.

UUU. [Reserved]

VVV. "Stack, chimney, vent, or duct" means any conduit or duct emitting particulate or gaseous emissions into the open air.

WWW. "Standard conditions" means the conditions existing at a temperature of 70° F (25° C) and pressure of 14.7 psia (760 mmHg).

XXX. "Standard cubic foot" means a measure of the volume of one cubic foot of gas at standard conditions.

YYY. "Startup" means [~~the~~] setting into operation [~~of~~] any air pollution control equipment, or process equipment [~~or process for any purpose~~].

ZZZ. "Stationary source" means any building, structure, facility or installation, which is either permanent or temporary, excluding a private residence, that emits or may emit any regulated air pollutant or any pollutant listed under Section 112(b) of the federal act, the Air Quality Control Act, or the laws and regulations in effect pursuant to the act. Several buildings, structures, facilities, or installations, or any combinations will be treated as a single stationary source if they belong to the same industrial grouping, are located on one or more contiguous or adjacent properties, and are under the control of the same person, or persons, or are under common control. Pollutant-emitting activities shall be treated as the same industrial grouping if they have the same first two digits of an applicable standard industrial classification (SIC) code as described in the standard industrial classification manual, or if they have the same first three digits of an applicable north american industry classification system (NAICS) code.

AAAA. "Sulfur dioxide" or "SO_2" means a pungent, colorless, poisonous gas composed of molecules containing a single atom of sulfur and two atoms of oxygen with a molecular weight of 64.07 g/mole.

BBBB. "Total reduced sulfur" means any combination of sulfur compounds, except sulfur dioxide and free sulfur, which test as reduced sulfur, including, but not limited to, hydrogen sulfide, methyl mercaptan, and ethyl mercaptan.

CCCC. "Total suspended particulate" or "TSP" means particulate matter as measured by the method described in 40 CFR Part 50, Appendix B.

DDDD. "Vapors" means the gaseous form of a substance, which exists in the liquid or solid state at standard conditions.

EEEE. "Visible emission" means an emission that can be seen because its opacity or optical density is above the threshold of vision.

FFFF. "Volatile organic compounds" or "VOC" means any compound of carbon, [~~which participates in atmospheric photochemical reactions~~] excluding carbon monoxide, carbon dioxide, carbonic acid, metallic carbides or carbonates, and ammonium carbonate, which participates in atmospheric photochemical reactions.

(1) VOC includes any such organic compound other than the following, which have been determined to have negligible photochemical reactivity: methane; ethane; methylene chloride (dichloromethane); 1,1,1-trichloroethane (methyl chloroform); 1,1,2-trichloro-1,2,2-trifluoroethane (CFC-113); trichlorofluoromethane (CFC-11); dichlorodifluoromethane (CFC-12); chlorodifluoromethane (HCFC-22); trifluoromethane (HFC-23); 1,2-dichloro 1,1,2,2-tetrafluoroethane (CFC-114); chloropentafluoroethane (CFC-115); 1,1,1-trifluoro 2,2-dichloroethane (HCFC-123); 1,1,1,2-tetrafluoroethane (HFC-134a); 1,1-dichloro 1-fluoroethane (HCFC-141b); 1-chloro 1,1-difluoroethane (HCFC-142b); 2-chloro-1,1,1,2-tetrafluoroethane (HCFC-124); pentafluoroethane (HCFC-125); 1,1,2,2-tetrafluoroethane (HFC-134); 1,1,1-trifluoroethane (HFC-143a); 1,1-difluoroethane (HFC-152a); parachlorobenzotrifluoride (PCBTF); cyclic, branched, or linear completely methylated siloxanes; acetone; perchloroethylene (tetrachloroethylene); [~~and perfluorocarbon compounds; and, any additional compounds which the EPA determines to have negligible photochemical reactivity.~~] 3,3-dichloro-1,1,1,2,2-pentafluoropropane (HCFC–225ca); 1,3-dichloro-1,1,2,2,3-pentafluoropropane (HCFC–225cb); 1,1,1,2,3,4,4,5,5,5-decafluoropentane(HFC 43–10mee); difluoromethane(HFC–32); ethylfluoride (HFC–161); 1,1,1,3,3,3-hexafluoropropane(HFC–236fa); 1,1,2,2,3-pentafluoropropane (HFC–245ca); 1,1,2,3,3-pentafluoropropane (HFC–245ea); 1,1,1,2,3-pentafluoropropane (HFC–245eb); 1,1,1,3,3-pentafluoropropane (HFC–245fa); 1,1,1,2,3,3-hexafluoropropane (HFC–236ea); 1,1,1,3,3-pentafluorobutane (HFC–365mfc); chlorofluoromethane (HCFC–31); 1 chloro-1-fluoroethane (HCFC–151a); 1,2-dichloro-1,1,2-trifluoroethane (HCFC–123a); 1,1,1,2,2,3,3,4,4-nonafluoro-4-methoxy-butane ($C_4F_9OCH_3$ or HFE-7100);

2-(difluoromethoxymethyl)-1,1,1,2,3,3,3-heptafluoropropane ($(CF_3)_2CFCF_2OCH_3$); 1-ethoxy-1,1,2,2,3,3,4,4,4-nonafluorobutane ($C_4F_9OC_2H_5$ or HFE-7200); 2-(ethoxydifluoromethyl)-1,1,1,2,3,3,3-heptafluoropropane ($(CF_3)_2CFCF_2OC_2H_5$); methyl acetate; 1,1,1,2,2,3,3-heptafluoro-3-methoxy-propane ($n\text{-}C_3F_7OCH_3$ or HFE-7000); 3-ethoxy-1,1,1,2,3,4,4,5,5,6,6,6-dodecafluoro-2-(trifluoromethyl) hexane (HFE-7500); 1,1,1,2,3,3,3-heptafluoropropane (HFC 227ea); methyl formate ($HCOOCH_3$); 1,1,1,2,2,3,4,5,5,5-decafluoro-3-methoxy-4-trifluoromethyl-pentane (HFE-7300); propylene carbonate; dimethyl carbonate; and perfluorocarbon compounds which fall into these classes:

(a) cyclic, branched, or linear, completely fluorinated alkanes;

(b) cyclic, branched, or linear, completely fluorinated ethers with no unsaturations;

(c) cyclic, branched, or linear, completely fluorinated tertiary amines with no unsaturations; and

(d) sulfur containing perfluorocarbons with no unsaturations and with sulfur bonds only to carbon and fluorine.

(2) For purposes of determining compliance with emissions limits, VOC will be measured by the test methods in the approved state implementation plan (SIP) or 40 CFR Part 60, Appendix A, as applicable. Where such a method also measures compounds with negligible photochemical reactivity, these negligibility-reactive compounds may be excluded as VOC if the amount of such compounds is accurately quantified, and such exclusion is approved by the enforcement authority.

(3) As a precondition to excluding these compounds as VOC or at any time thereafter, the enforcement authority may require an owner or operator to provide monitoring or testing methods and results demonstrating, to the satisfaction of the enforcement authority, the amount of negligibly-reactive compounds in the source's emissions.

(4) For purposes of federal enforcement for a specific source, the EPA shall use the test methods specified in the applicable EPA-approved SIP, in a permit issued pursuant to a program approved or promulgated under Title V of the act, or under 40 CFR Part 51, Subpart I or Appendix S, or under 40 CFR Parts 52 or 60. The EPA shall not be bound by any state determination as to appropriate methods for testing or monitoring negligibly-reactive compounds if such determination is not reflected in any of the above provisions.

(5) The following compound(s) are VOC for purposes of all recordkeeping, emissions reporting, photochemical dispersion modeling and inventory requirements which apply to VOC and shall be uniquely identified in emission reports, but are not VOC for purposes of VOC emissions limitations or VOC content requirements: t-butyl acetate.

(6) For the purposes of determining compliance with California's aerosol coatings reactivity-based regulation, (as described in the California Code of Regulations, Title 17, Division 3, Chapter 1, Subchapter 8.5, Article 3), any organic compound in the volatile portion of an aerosol coating is counted towards that product's reactivity-based limit. Therefore, the compounds identified in Subsection FFFF of 20.11.1.7 NMAC as negligibly reactive and excluded from EPA's definition of VOCs are to be counted towards a product's reactivity limit for the purposes of determining compliance with California's aerosol coatings reactivity-based regulation.

(7) For the purposes of determining compliance with EPA's aerosol coatings reactivity based regulation (as described in 40 CFR Part 59 – *National Volatile Organic Compound Emission Standards for Consumer and Commercial Products*) any organic compound in the volatile portion of an aerosol coating is counted towards the product's reactivity-based limit, as provided in 40 CFR Part 59, Subpart E. Therefore, the compounds that are used in aerosol coating products and that are identified in Subsection FFFF of 20.11.1.7 NMAC as negligibly reactive and excluded from EPA's definition of VOC are to be counted towards a product's reactivity limit for the purposes of determining compliance with EPA's aerosol coatings reactivity-based national regulation, as provided in 40 CFR Part 59, Subpart E.

GGGG. "Measurements, abbreviations. and acronyms"

A-BC AQCB-Albuquerque - Bernalillo county air quality control board
ABT-averaging, banking and trading (program)
AIRS-aerometric information retrieval system
AMPA-Albuquerque metropolitan planning area
[~~APCD~~-~~Air Pollution Control Division~~]
API-American petroleum institute
AQIA-air quality impact assessment
AQI-air quality index
AQS-air quality services
ASE-national institute for automotive service excellence
ASTM-American society for testing and materials
ATS-allowance tracking system
BACT-best available control technology
Bhp-brake horsepower
Btu-British thermal unit
C-Celsius
CAA(A)-federal Clean Air Act (Amendments)
CEM-continuous emission monitor
CFC(s) -chlorofluorocarbon(s)
cfh-cubic feet per hour
cfm-cubic feet per minute
CFR-code of federal regulations
CO_2-carbon dioxide.
CO-carbon monoxide.
COG-mid-region council of governments
CMAQ-congestion mitigation and air quality
cu. in.-cubic inch(es)
DER-discrete emission reduction
DOE-department of energy
DOT-U.S. department of transportation
DPM-development process manual
DRB-development review board
EA-environmental assessment
EHD-environmental health department
EI-emission inventory
EIS-environmental impact statement
EPA-U.S. environmental protection agency
EPC-environmental planning commission
ERC-emission reduction credit
F-Fahrenheit
FHWA-federal highway administration, DOT
FMVCP-federal motor vehicle control program
FR-federal register
ft.-feet
FTA-federal transit administration, DOT
g-gram(s)
g/mole-grams per mole
gal -U.S. gallon(s)
GVW-gross vehicle weight
GVWR-gross vehicle weight rating
h-hour(s)
HAP-hazardous air pollutants
HC-hydrocarbon(s)
Hg-mercury
hp.-horsepower
I/M-inspection/maintenance
in.-inch(es)
ISTEA-Intermodal Surface-Transportation Efficiency Act (see SAFETEA-LU)
K-Kelvin
kg-kilogram(s)
km-kilometer(s)
kPa-kilopascal(s)
lb.-pound(s)
lb/day-pounds per day
lb-ft-pound-feet
lb/hr-pounds per hour
lb/yr-pounds per year
LAER-lowest achievable emission rate
LNG-liquefied natural gas
LPG-liquefied petroleum gas
LRTP-long range transportation plan
m-meter(s)
MACT-maximum achievable control technology
max.-maximum
MCO-manufacturer's certificate of origin
µg-microgram
µg/m³-microgram per cubic meter
mg-milligram(s)

mg/m^3-milligram per cubic meter
mi.-mile(s)
min-minute(s)
ml-milliliter(s)
mm-millimeter(s)
MMBtu-million Btu
mmHg-millimeters of mercury
mph-miles per hour
MPO-metropolitan planning organization
MRCOG-mid-region council of governments
MSERC-mobile source emission reduction credits
MSMTC-mobile source modeling technical committee
MTBE-methyl tertiary butyl ether
MVD-motor vehicle division
MWe-megawatt electrical
N_2-nitrogen
NAAQS-national ambient air quality standards
NAMS-national air monitoring station
NCore- national core multi-pollutant monitoring network
NDIR- NonDispersive InfraRed
NEPA-National Environmental Policy Act
NESCAUM/MARAMA-northeast states for coordinated air use management/mid-atlantic regional air management association
NESHAP-national emission standards for hazardous air pollutants
NIST-national institute of standards and technology
NM-New Mexico
NMAC-New Mexico administrative code
NMSA-New Mexico statutes annotated
NO-nitric oxide
NO_2-nitrogen dioxide
NOx -oxides of nitrogen
No-number
NOV-notice of violation
NMHC-non-methane hydrocarbons
NSPS-new source performance standards
NSR-new source review
O_2-oxygen
O_3-ozone
OMTR-open market trading rule
OTAG-ozone transport assessment group
OTC-ozone transport commission
Pb-lead
PIC-public involvement committee
PM-particulate matter
$PM_{2.5}$-particulate matter less than 2.5 microns
PM_{10}-particulate matter less than 10 microns
ppm-parts per million by volume
ppm C-parts per million, carbon
PSD-prevention of significant deterioration
~~**[PSI**-Pollutant Standard Index~~]
psi-pounds per square inch
psia-pounds per square inch absolute
psig-pounds per square inch gauge
PTE-potential to emit
PWD-pathological waste destructor
QF-qualifying facility
R-Rankin
RACT-reasonably available control technology
R&D-research & development
RECLAIM-regional clean air incentives market
ROG-reactive organic gases
rpm-revolutions per minute
RTA-regional transit authority
RTC-RECLAIM trading credit
RVP-reid vapor pressure
s-second(s)
SAE-society of automotive engineers
SAFETEA-LU-The Safe, Accountable, Flexible, Efficient Transportation Equity Act – A Legacy for Users
SBAP-small business assistance program
scf-standard cubic foot
SI-international system of units
SIP-state implementation plan
SLAMS-state and local air monitoring station
SMOG-SMoke + fOG
SO_2-sulfur dioxide
State DOT-New Mexico department of transportation
STIP-state transportation improvement program
TCC-transportation coordinating committee
TCM-transportation control measure
TES-transportation evaluation study
TIP-transportation improvement program
TMA-transportation management association
ton/yr-tons per year
TPTG-transportation program task group
tpy-tons per year
TSP-total suspended particulate
UPWP-unified planning work program
UTPPB-urban transportation planning policy board
U.S.-United States
UV-ultraviolet
VE-visible emission(s)
VIN-vehicle identification number
VMT-vehicle miles traveled
VOC-volatile organic compounds
VPMD-vehicle pollution management division
%-percent
°-degree(s)

[3/21/77. . .11/12/81, 11/21/81, 3/16/89, 6/16/92, 2/26/93, 9/23/94, 12/16/94, 12/1/95, 8/1/96; 20.11.1.7 NMAC - Rn, 20 NMAC 11.01.I.7, 10/1/02; A, 7/1/04; A, 9/14/09]

20.11.1.9 SAVINGS CLAUSE: Any amendment to 20.11.1 NMAC which is filed with the state records center shall not affect actions pending for violation of a city or county ordinance, [~~Air Quality Control Board Standard 1, Board Regulations No. 1, 2, and 26,~~] or [~~Part 1~~] 20.11.1 NMAC. Prosecution for a violation under prior regulation wording shall be governed and prosecuted under the statute, ordinance, part or regulation section in effect at the time the violation was committed.
[12/1/95; 20.11.1.9 NMAC - Rn, 20 NMAC 11.01.I.9, 10/1/02; A, 9/14/09]

20.11.1.10 SEVERABILITY: If any section, paragraph, sentence, clause or word of [~~this part~~] 20.11.1 NMAC or any federal standards incorporated herein is for any reason held to be unconstitutional or otherwise invalid by any court, the decision shall not affect the validity of remaining provisions of [~~this part~~] 20.11.1 NMAC.
[12/1/95; 20.11.1.10 NMAC - Rn, 20 NMAC 11.01.I.10, 10/1/02; A, 9/14/09]

20.11.1.11 DOCUMENTS: Documents incorporated and cited in [~~this part~~] 20.11.1 NMAC may be viewed at the Albuquerque environmental health department, 400 Marquette NW, Albuquerque, NM.
[12/1/95; 20.11.1.11 NMAC - Rn, 20 NMAC 11.01.I.11 & A, 10/1/02; A, 9/14/09]

20.11.1.14 [~~**INTERPRETATION:** Except as expressly provided to the contrary in these regulations, whenever two or more parts of these regulations limit, control or regulate the emissions of a particular air contaminant, the more restrictive or stringent shall govern.~~] [Reserved]
[3/24/82; 20.11.1.14 NMAC - Rn, 20 NMAC 11.01.II.3, 10/1/02; A, 9/14/09]

ALBUQUERQUE-BERNALILLO COUNTY AIR QUALITY CONTROL BOARD

This is an amendment to 20.11.8 NMAC, Sections 1, 2, 5, 6, 8, 11, 12, and 13, effective 9/14/2009.

20.11.8.1 ISSUING AGENCY: Albuquerque - Bernalillo County Air Quality Control Board. P.O. Box 1293, Albuquerque, NM 87103. Telephone: (505) [~~768-2600~~] 768-2601.
[20.11.8.1 NMAC - N, 7/1/04; A, 9/14/09]

20.11.8.2 SCOPE:

A. 20.11.8 NMAC is applicable [~~to the city of Albuquerque and~~] within Bernalillo county.

B. Exempt: 20.11.8 NMAC does not apply to sources within Bernalillo county, which are located on Indian lands over which the Albuquerque - Bernalillo county air quality control board lacks jurisdiction.
[20.11.8.2 NMAC - N, 7/1/04; A, 9/14/09]

20.11.8.5 EFFECTIVE DATE: [~~The effective date of Part 8 is,~~] July 1**,** 2004, unless a later date is cited at the end of a section. The effective date of a specific section is located at the end of each section within the historical brackets. As required by the New Mexico Air Quality Control

Act, Chapter 74, Article 2, Section 6 NMSA 1978, no regulation or emission control requirement or amendment thereto, or repeal thereof, shall become effective until 30 days after its filing under the State Rules Act, Chapter 14, Article 4 NMSA 1978.
[20.11.8.5 NMAC - N, 7/1/04; A, 9/14/09]

20.11.8.6 OBJECTIVE: [~~The objective of 20.11.8 NMAC is~~] To adopt local ambient air quality standards that are identical to the federal National Primary and Secondary Ambient Air Quality Standards codified at 40 CFR Part 50, and to adopt applicable state *Ambient Air Quality Standards* codified at 20.2.3 NMAC.
[20.11.8.6 NMAC - N, 7/1/04; A, 9/14/09]

20.11.8.8 SAVINGS CLAUSE: Any amendment to *Ambient Air Quality Standards*, 20.11.8 NMAC, [~~that~~] which is filed with the state records center, shall not affect actions pending for violation of a city or county ordinance, the air quality regulations for Albuquerque and Bernalillo county or a permit issued by the department. Prosecution for a violation under a prior statute, ordinance, regulation or permit shall be governed and prosecuted under the statute, ordinance or regulation in effect at the time the violation was committed.
[20.11.8.8 NMAC - N, 7/1/04; A, 9/14/09]

20.11.8.11 INCORPORATION OF FEDERAL AMBIENT AIR QUALITY STANDARDS: Except as otherwise provided, the National Primary and Secondary Ambient Air Quality Standards of the United States environmental protection agency including the General Provisions thereto, codified at 40 CFR Part 50 (including appendices), as amended through [~~July 18, 1997~~] January 12, 2009, are hereby incorporated into 20.11.8 NMAC. Section 20.11.8.13 NMAC is a summary of the federal and state standards incorporated in 20.11.8 NMAC.
[20.11.8.11 NMAC - N, 7/1/04; A, 9/14/09]

20.11.8.12 INCORPORATION OF STATE AMBIENT AIR QUALITY STANDARDS: Except as otherwise provided, the state *Ambient Air Quality Standards* of the environmental improvement board codified at 20.2.3 NMAC [~~, effective October 31, 2002,~~] are hereby incorporated into 20.11.8 NMAC. Section 20.11.8.13 NMAC is a summary of the federal and state standards incorporated in 20.11.8 NMAC.
[20.11.8.12 NMAC - N, 7/1/04; A, 9/14/09]

[*Continued on page 1072*]

20.11.8.13 SUMMARY OF FEDERAL AND STATE AMBIENT AIR QUALITY STANDARDS:

Pollutant	Standards			
	Reference	Federal Primary	Federal Secondary	New Mexico State
Carbon Monoxide (CO)				
8-hour average	40 CFR 50.8	9[~~.0~~] ppm	none	8.7 ppm
1-hour average	40 CFR 50.8	35 ppm	none	13.1 ppm
Nitrogen Dioxide (NO_2)				
24-hour average	20.2.3.111 NMAC	none	none	0.10 ppm
Annual arithmetic mean	40 CFR 50.11	0.053 ppm	0.053 ppm	0.05 ppm
Ozone (O_3)				
~~[1-hour average~~		~~0.120 ppm~~	~~0.120 ppm~~	~~none~~]
8-hour average	40 CFR 50.10	0.08 ppm	0.08 ppm	none
(The 1997 standard - and the implementation rules for that standard - will remain in place for implementation purposes as EPA undertakes rulemaking to address the transition from the 1997 ozone standard to the 2008 ozone standard).				
8-hour average	40 CFR 50.15	0.075 ppm	0.075 ppm	none
(Effective May 27, 2008)				
Sulfur Dioxide (SO_2)				
24-hour average	40 CFR 50.4	0.14 ppm	none	0.10 ppm
3-hour average	40 CFR 50.5	none	0.5 ppm	none
Annual (arithmetic mean)	40 CFR 50.4	0.030 ppm	none	0.02 ppm
Particulate Matter ($PM_{2.5}$)				
~~[24-hour average~~		~~65 µg/m³~~	~~65 µg/m³~~	~~none~~]
24-hour average	40 CFR 50.13	35 µg/m³	35 µg/m³	none
(Effective December 18, 2006)				
Annual (arithmetic mean)	40 CFR 50.7 & 40 CFR 50.13	15.0 µg/m³	15.0 µg/m³	none
Particulate Matter (PM_{10})				
24-hour average	40 CFR 50.6	150 µg/m³	150 µg/m³	none
~~[Annual arithmetic mean~~		~~50 µg/m³~~	~~50 µg/m³~~	~~none~~]
Lead (Pb)				
~~[Quarterly arithmetic mean~~		~~1.5 µg/m³~~	~~1.5 µg/m³~~	~~none~~]
Rolling 3-month average	40 CFR 50.16	0.15µg/m³	0.15µg/m³	none
(Effective 1 year after date of area attainment designation)				
Hydrogen Sulfide				
1-hr average	20.2.3.110 NMAC	none	none	0.010 ppm
Total Reduced Sulfur				
1/2-hour average	20.2.3.110 NMAC	none	none	0.003 ppm
Particulate Matter (TSP)				
24-hour average	20.2.3.109 NMAC	none	none	150 µg/m³
7-day average	20.2.3.109 NMAC	none	none	110 µg/m³
30-day average	20.2.3.109 NMAC	none	none	90 µg/m³
Annual geometric mean	20.2.3.109 NMAC	none	none	60 µg/m³

[20.11.8.13 NMAC - N, 7/1/04; A, 9/14/09]

NEW MEXICO BOARD OF CHIROPRACTIC EXAMINERS

This is an amendment to 16.4.15 NMAC Section 11, effective 09/11/2009.

16.4.15.11 CHIROPRACTIC FORMULARY: [~~RESERVED~~]

A. Herbal medicines may be the crude substance or a prepared form that renders the crude substance clinically useful. it may include preparations, concentrates, refinements, isolates, extracts, and derivatives of herbs.

B. All homeopathic preparations medicines include all medicines named in the *homeopathic pharmacopoeia of the United States.*

C. Over-the-counter drugs to include, but not limited to, all drugs listed in the *PDR for OTC drugs* or other compendium of *United States otc* drugs:

(1) all vitamins;

(2) all minerals.

D. Enzymes to include those produced for therapeutic use to include digestive enzymes, proteolytic enzymes, anti-inflammatory enzymes and other therapeutic enzymes.

E. Glandular products to include products produced from, extracted from, isolated from animal glandular tissue. It includes desiccated or otherwise processed whole glandular tissue, including protein, lipid and carbohydrate constituents of glandular tissue and, hormones, enzymes and secretions.

F. Protomorphogens to include those components of the cell nuclear material that are responsible for morphogenic determination of cell characteristics.

G. Live cell products includes therapeutic agents that are live cells or that are produced or secreted, extracted or isolated from live cells:

(1) gerovital;

(2) all amino acids to include peptides and amino acid combinations.

H. All dietary supplements as listed in comprehensive natural medicines database, PDR for nutritional supplements or other compendium or commercial catalogue of dietary supplements.

I. All foods for special dietary use.

J. Bioidentical hormones to include all hormones compounds, or salt forms of those compounds, that have exactly the same chemical and molecular structure as hormones that are produced in the human body:

(1) sterile water;

(2) sterile saline;

(3) sarapin or its generic;

(4) caffeine;

(5) procaine HCl;

(6) oxygen;

(7) epinephrine;

(8) vapocoolants.

[16.4.15.11 NMAC - N, 09/11/2009]

NEW MEXICO DEPARTMENT OF GAME AND FISH

TITLE 19 NATURAL RESOURCES AND WILDLIFE
CHAPTER 31 HUNTING AND FISHING
PART 6 MIGRATORY GAME BIRD

19.31.6.1 ISSUING AGENCY: New Mexico Department of Game and Fish.
[19.31.6.1 NMAC - Rp, 19.31.6.1 NMAC, 8-31-2009]

19.31.6.2 SCOPE: Hunters of migratory game birds. Additional requirements may be found in Chapter 17 NMSA 1978 and Chapters 30 and 32 through 36 of Title 19.
[19.31.6.2 NMAC - Rp, 19.31.6.2 NMAC, 8-31-2009]

19.31.6.3 STATUTORY AUTHORITY: 17-1-14 and 17-1-26 NMSA 1978 provide that the New Mexico game commission has the authority to establish rules and regulations that it may deem necessary to carry out the purpose of Chapter 17 NMSA 1978 and all other acts pertaining to protected mammals, birds, and fish.
[19.31.6.3 NMAC - Rp, 19.31.6.3 NMAC, 8-31-2009]

19.31.6.4 DURATION: August 31, 2009 - March 31, 2010.
[19.31.6.4 NMAC - Rp, 19.31.6.4 NMAC, 8-31-2009]

19.31.6.5 EFFECTIVE DATE: August 31, 2009 unless later date is cited at end of individual sections.
[19.31.6.5 NMAC - Rp, 19.31.6.5 NMAC, 8-31-2009]

19.31.6.6 OBJECTIVE: Establishing seasons on dove, band-tailed pigeon, sandhill crane, American coot, common moorhen, common snipe, ducks, geese, sora, Virginia rail, and setting falconry seasons for migratory game birds.
[19.31.6.6 NMAC - Rp, 19.31.6.6 NMAC, 8-31-2009]

19.31.6.7 DEFINITIONS: Areas, species, non-toxic shot, and possession limit defined.

A. "Adult/youth" (A/Y) as used herein, shall mean that hunt designation where the adult and youth are permitted to hunt together.

B. "Arrows" shall mean only those arrows or bolts having broadheads with steel cutting edges.

C. "Baiting" shall mean the placing, exposing, depositing, distributing, or scattering of any salt, grain, scent or other feed on or over areas where hunters are attempting to take migratory game birds.

D. "Bernardo north duck hunt area" (BND) shall mean that area north of U.S. 60 on Bernardo waterfowl management area (WMA).

E. "Bow" shall mean compound, recurve, or long bow. Sights on bows shall not project light nor magnify.

F. "Central flyway" shall mean that portion of New Mexico east of the continental divide, with the exception of the Jicarilla Apache Indian reservation.

G. "Crossbows" shall mean a device with a bow limb or band of flexible material that is attached horizontally to a stock and has a mechanism to hold the string in a cocked position. Sights on crossbows shall not project light nor magnify.

H. "Dark goose" shall mean Canada goose or greater white-fronted goose.

I. "Department" shall mean the New Mexico department of game and fish.

J. "Department offices" shall mean department offices in Santa Fe, Albuquerque, Raton, Las Cruces, or Roswell.

K. "Director" shall mean the director of the New Mexico department of game and fish.

L. "Dove north zone" (north zone) shall mean that portion of New Mexico north of I-40 from the Arizona-New Mexico border to Tucumcari and U.S 54 at its junction with I-40 at Tucumcari to the New Mexico-Texas border.

M. "Dove south zone" (south zone) shall mean that portion of New Mexico south of I-40 from the Arizona-New Mexico border to Tucumcari and U.S 54 at its junction with I-40 at Tucumcari to the New Mexico-Texas border.

N. "Eastern New Mexico sandhill crane hunt area" (eastern) shall mean that area in the following counties: Chaves, Curry, De Baca, Eddy, Lea, Quay, and Roosevelt.

O. "Electronic motion decoys" shall mean decoys such as spinning wing decoys that operate by electric motors or electronic controls.

P. "Established road" is defined as follows:

(1) a road, built or maintained by equipment, which shows no evidence of ever being closed to vehicular traffic by such means as berms, ripping, scarification, reseeding, fencing, gates, barricades or posted closures;

(2) a two-track road completely void of vegetation in the tracks which shows use prior to hunting seasons for other purposes such as recreation, mining, logging, and ranching and shows no evidence of ever being closed to vehicular traffic by such means as berms, ripping, scarification, reseeding, fencing, gates, barricades or posted closures.

Q. "Estancia valley sandhill crane hunt area" (EV) shall mean that area beginning at Mountainair bounded on the west by N.M. highway 55 north to N.M. 337, north to N.M. 14, and north to Interstate 25; on the north by Interstate 25 east to U.S. 285; on the east by U.S. 285 south to U.S. 60; and on the south by U.S. 60 from U.S. 285 west to N.M. 55 in Mountainair.

R. "Falconry" shall mean hunting migratory game birds using raptors.

S. "License year" shall mean the period from April 1 through March 31.

T. "Light geese" shall mean snow geese, blue phase snow geese, and Ross's geese.

U. "Light goose conservation order" shall mean those methods, bag and possession limits, and dates approved by the U. S. fish and wildlife service (USFWS) towards reducing over-abundant light goose populations.

V. "Middle Rio Grande valley dark goose hunt area" shall mean Sierra, Socorro and Valencia counties.

W. "Middle Rio Grande valley sandhill crane hunt area" (MRGV) shall mean Valencia and Socorro counties.

X. "Migratory game bird" shall mean band-tailed pigeon, Eurasian-collared dove, mourning dove, white-winged dove, sandhill crane, American coot, common moorhen, common snipe, ducks, geese, sora, and Virginia rail.

Y. "Modern firearms" shall mean center-fire firearms, not to include any fully automatic firearms. Legal shotguns shall be only those shotguns capable of being fired from the shoulder.

Z. "Muzzle-loader or muzzle-loading firearms" shall mean those rifles and shotguns in which the charge and projectile are loaded through the muzzle. Only blackpowder, pyrodex or equivalent blackpowder substitute may be used. Use of smokeless powder is prohibited. Legal muzzle-loader shotguns shall be only those shotguns capable of being fired from the shoulder.

AA. "Non-toxic shot" shall mean that non-toxic shot approved for use by the USFWS.

BB. "North zone" shall mean that portion of the Pacific flyway north of I-40 from the Arizona-New Mexico border to the continental divide; and that portion of the central flyway north of I-40 from the continental divide to Tucumcari and U.S. 54 at its junction with I-40 at Tucumcari to the New Mexico-Texas border.

CC. "Pacific flyway" shall mean that portion of New Mexico west of the continental divide including the Jicarilla Apache Indian reservation.

DD. "Permanent mobility limitation" shall mean an individual that permanently has: restricted movement in both arms, or is restricted to the use of a walker, wheelchair, or two crutches to walk, or has a combination of disabilities that cause comparable substantial functional limitations. EXCEPTION: For the purposes of hunting migratory game birds from a vehicle, mobility limitation individuals are those that have permanently lost one or both legs.

EE. "Possession limit" shall mean twice the daily bag limit one can have in their ownership, except where otherwise defined.

FF. "Protected species" shall mean any of the following animals:

(1) all animals defined as protected wildlife species and game fish under Section 17-2-3 New Mexico Statutes Annotated 1978 Compilation;

(2) all animals listed as endangered species or subspecies as stated in regulation(s) set by the state game commission.

GG. "Regular band-tailed pigeon hunting area" (regular BPHA) shall mean that portion of New Mexico not included in the southwest band-tailed pigeon hunt area.

HH. "Retention" or "retain" shall mean the holding of in captivity.

II. "South zone" shall mean that portion of the Pacific flyway south of I-40 from the Arizona-New Mexico border to the continental divide; and that portion of the central flyway south of I-40 from continental divide to Tucumcari and U.S. 54 at its junction with I-40 at Tucumcari to the New Mexico-Texas border.

JJ. "Southwest band-tailed pigeon hunting area" (southwest BPHA) shall mean that portion of New Mexico both south of U.S. 60 and west of I-25.

KK. "Southwest New Mexico sandhill crane hunt area" (SW) shall mean that area bounded on the south by the New Mexico/Mexico border; on the west by the New Mexico/Arizona border north to Interstate 10; on the north by Interstate 10 east to U.S. 180, north to N.M. 26, east to N.M. 27, north to N.M. 152, and east to Interstate 25; on the east by Interstate 25 south to Interstate 10, west to the Luna county line, and south to the New Mexico/Mexico border.

LL. "State game commission owned properties" shall mean all department owned or managed waterfowl management areas, wildlife management areas, Sandhills prairie conservation area and lesser prairie-chicken areas.

MM. "Unlimited" shall mean there is no set limit on the number of permits or licenses established for the described hunt areas.

NN. "Waterfowl management area" (WMA) shall mean Bernardo, Brantley, Casa Colorada, Charette lake, Jackson lake, La Joya, McAllister lake, Salt lake, Seven Rivers, Tucumcari, and W.S. Huey state game commission owned or managed waterfowl management areas.

OO. "Wildlife management area" shall mean Big Hatchet, Colin Neblett, E.S. Barker, Humphries, Marquez, Rio Chama, Sargent, Socorro-Escondida, and Water canyon wildlife management areas, the Sandhills prairie conservation area, and state game commission owned lesser prairie-chicken areas.

PP. "Youth" shall mean those less than 18 years of age except where otherwise defined.

QQ. "Youth waterfowl hunting days" shall mean the special seasons where only those under 16 years of age may hunt ducks and geese. A supervising adult must accompany the youth hunter.

[19.31.6.7 NMAC - Rp, 19.31.6.7 NMAC, 8-31-2009]

19.31.6.8 LICENSE AND APPLICATION REQUIREMENTS:

A. License: It shall be unlawful to hunt migratory game birds without having purchased a valid license for the current license year. Valid licenses are general hunting, or general hunting and fishing, or junior general hunting, or junior general hunting and fishing, or senior or handicapped general hunting, or senior or handicapped general hunting and fishing, or small game, or junior or senior small game and fishing, or non-resident small game, and temporary small game 4-day licenses. A migratory bird permit number shall be required. A habitat stamp is required for those hunting on US forest service and bureau of land management properties. Hunters from 18 through 69 years of age must also purchase a habitat management and access validation except for resident 100% disabled veterans. Waterfowl hunters 16 years of age and older are required to have on their possession a federal migratory bird hunting and conservation stamp (duck

stamp).

(1) For band-tailed pigeon hunting and falconry: in addition to a valid license, a free band-tailed pigeon permit obtained from department offices or website shall be required.

(2) For MRGV dark goose hunting: in addition to a valid license, a free MRGV dark goose permit obtained from department offices or website shall be required.

(3) For waterfowl hunting on Bernardo WMA and La Joya WMA: in addition to a valid license, a free Bernardo/La Joya WMA permit obtained from the department website or offices shall be required.

(4) For eastern sandhill crane hunting and falconry: in addition to a valid license, a free federal sandhill crane hunting permit shall be required. Permits may be obtained from department offices or website.

(5) For Estancia valley sandhill crane, middle Rio Grande valley sandhill crane, middle Rio Grande youth-only sandhill crane, southwest sandhill crane hunting, Bernardo WMA light goose, and Bernardo WMA youth-only waterfowl hunting: in addition to a valid license, a special permit obtained by drawing shall be required.

(6) For Estancia valley sandhill crane falconry hunting: in addition to a valid license, falconers shall have in their possession a special permit obtained from only the Santa Fe and Albuquerque offices. Up to 5 permits may be issued on a first come basis.

(7) For the light goose conservation order: in addition to a valid license, a free light goose conservation order permit obtained from department offices or website shall be required.

B. Valid dates of license or permit: All permits or licenses shall be valid only for the dates, legal sporting arms, bag limit and area specified by the hunt code printed on the permit or license.

C. Applications: Applications for Bernardo WMA light goose, Bernardo WMA youth-only light goose, Bernardo WMA youth-only waterfowl, EV sandhill crane, MRGV sandhill crane, SW sandhill crane, and MRGV youth-only sandhill crane hunt permits shall be submitted on the appropriate application form or department website.

(1) For permits issued by drawing, the appropriate application fee as defined by 19.30.9 NMAC shall be required by each applicant per application submitted.

(2) No more than four persons may apply per application. For the MRGV youth-only sandhill crane hunt, no more than two persons may apply per application.

(3) It shall be unlawful to submit more than one application per species per year, unless otherwise specifically allowed by rule. Those submitting more than one application per species will result in the rejection of all applications for that species.

(4) Applications may be returned to the sender if such applications are not on the proper form or do not supply adequate information.

(5) Applicants may apply for a first, second and third choice of seasons if applicable. A maximum of one permit per species hunt code will be awarded to successful applicants unless otherwise specifically allowed by rule.

(6) All applications must be mailed to the Santa Fe office or submitted via the department website unless otherwise specifically allowed by rule.

(a) A person desiring a band-tailed pigeon, MRGV dark goose, or Bernardo/La Joya WMA permit shall apply in person at one of the department offices, by mail to the Santa Fe office only, or via the department website. Applicants shall submit their name, mailing address, and the number from their valid hunting license.

(b) A person desiring an EV sandhill crane falconry permit shall apply in person to only the department's Albuquerque or Santa Fe offices, or by mail to the Santa Fe office only.

(7) The application deadline date for the Bernardo WMA youth-only waterfowl; and EV, MRGV, MRGV youth-only, and SW sandhill crane hunt permits shall be the second Wednesday in September.

(a) for the Bernardo WMA youth-only waterfowl hunt permits, no more than three persons may apply per application;

(b) up to two hunt choices may be awarded by drawing for the Bernardo youth only waterfowl permits;

(c) if any permits are available after the drawing, a person may submit a new application at one of the department offices; up to 2 hunt choices may be awarded;

(d) hunters may have a maximum of 4 Bernardo youth-only waterfowl permits per license year; and

(e) only two applications per hunt code will be drawn, or issued after the drawing for Bernardo youth only waterfowl permits.

(8) The deadline date for application for the Bernardo WMA light goose hunt permits shall be the first Wednesday in November.

(9) If applications for permits exceed the number of available permits, as herein established, the available permits shall be allotted by means of a random public drawing in the Santa Fe office of the department of game and fish.

(10) If any permits remain after the original deadline, the director may authorize a new deadline. A person who is not awarded a permit for which he applied may submit a new application for a permit if such permits remain available.

D. Youth hunts: Only applicants who have not reached their 18th birthday by the opening day of the hunt are eligible to apply for or participate in a youth-only hunt. EXCEPTION: During the youth waterfowl hunt days only those who have not reached their 16th birthday may hunt waterfowl.

[19.31.6.8 NMAC - Rp, 19.31.6.8 NMAC, 8-31-2009]

19.31.6.9 MANNER AND METHODS FOR MIGRATORY GAME BIRDS:

A. Season and hours: Migratory game birds may be hunted or taken only during open seasons and only during the period from one-half hour before sunrise to sunset, unless otherwise specifically allowed by rule.

(1) On wildlife management areas, the lesser prairie-chicken areas, and the Sandhills prairie conservation area hunting hours shall be from one-half hour before sunrise to sunset.

(2) On waterfowl management areas (WMA)s and the Bottomless lakes overflow, hunting hours shall mean from one-half hour before sunrise to 1:00 p.m. For hunting September teal on Bernardo and La Joya WMAs hunting hours are from one-half hour before sunrise to sunset.

(3) During the light goose conservation order hunt dates, hunting hours shall mean from one-half hour before sunrise to one-half hour after sunset.

B. Bag limit: It is unlawful for any person to hunt for or take more than one daily bag limit allowed by regulation, unless otherwise specifically allowed by rule.

(1) There shall be no daily bag or possession limit for Eurasian-collared dove.

(2) There shall be no daily bag or possession limit for light geese during the light goose conservation order hunt dates.

C. Seizure: Any conservation officer or other officer authorized to enforce game laws and regulations shall seize the carcasses of any migratory game bird that are illegally obtained.

D. Use of bait: It shall be unlawful for anyone to take or attempt to take any migratory game bird by use of bait such as grain, salt or other feed.

E. Live animals: It shall be unlawful to use live animals as a blind or decoy in taking or attempting to take any migratory game bird.

F. Use of calling devices: It shall be unlawful to use any electrically or mechanically recorded calling device in taking or attempting to take any migratory game bird, unless otherwise specifically allowed by rule. During the light goose

conservation order hunt dates, electronic calling devices are allowed.

G. Killing out-of-season: It shall be unlawful to kill any migratory game bird out-of-season.

H. Legal sporting arms and ammunition:

(1) The following are legal sporting arms for migratory game birds:

(a) shotguns firing shot, shotguns shall not be capable of holding no more than three shells;

(b) muzzle-loading shotguns firing shot;

(c) bows and arrows;

(d) crossbows for individuals that qualify with a permanent mobility limitation; and

(e) during the light goose conservation order hunt dates, as listed herein, shotguns capable of holding more than three shells are lawful.

(2) Non-toxic shot use is required for hunting:

(a) all migratory game bird species, excluding dove, band-tailed pigeons, and eastern sandhill cranes; and

(b) on all state game commission owned lands.

(3) Use of lead shot: It shall be unlawful for any person hunting migratory game birds, other than dove, band-tailed pigeon and eastern sandhill crane, to hunt with or be in possession of any shotgun shells loaded with toxic shot or for any person using a muzzleloader to be in possession of lead shot.

I. Drugs and explosives: It shall be unlawful to use any form of drug on an arrow or use arrows driven by explosives.

J. Proof of species or sex:

(1) One fully feathered wing must remain attached to all migratory game birds, except dove and band-tailed pigeon, until the bird has arrived at the personal abode of the possessor or storage facility.

(2) All Eurasian-collared dove in possession must have an identifiable feathered wing attached until the bird has arrived at the personal abode of the possessor or storage facility. Any harvested dove without an identifiable wing attached, will count towards the daily dove bag and possession limits.

K. Possession or sale of migratory game bird: It shall be unlawful to possess, sell, or offer for sale all or part of any migratory game bird except as provided below:

(1) License or permit: A person may possess migratory game bird or parts thereof that they have lawfully taken (killed) under license or permit.

(2) Game taken by another: Any person may have in their possession or under their control any migratory game bird or parts thereof that have been lawfully taken by another person, if they possess a written statement which shall be provided by the donor of the migratory game bird, or parts thereof, and which shall contain the following:

(a) the kind and number of game parts donated;

(b) the date and county where the game was lawfully taken;

(c) the donor's name, address, and the number of the hunting license under which the game was lawfully taken; and

(d) the date and place of the donation.

(3) Retention of live animals: It shall be unlawful to retain migratory game bird in a live condition except under permit or license issued by the director for the following purposes:

(a) zoos open for public display;

(b) in class A parks;

(c) in projects for scientific research and propagation;

(d) a rehabilitation permit;

(e) under a falconry permit, only those birds listed on the permit;

(f) under a scientific collection permit, one may collect and possess only those migratory game bird species listed on the permit; and

(g) in transit through New Mexico when the transporter can demonstrate proof of legal possession of the migratory game bird being transported.

(4) Sale of game animal parts: It shall be unlawful to sale or barter any parts or feathers from migratory game birds.

(5) Falconry provisions for possession: the falconry hunter shall not retain nor possess any migratory game bird of bird taken by a raptor except those species of protected birds taken during open falconry season.

L. Release of wildlife: It shall be unlawful for any person or persons to release, intentionally or otherwise, or cause to be released in this state any migratory game bird, without first obtaining a permit from the department of game and fish.

M. Use of vehicles and roads in hunting migratory game birds:

(1) Roads: It shall be unlawful to shoot at, wound, take, attempt to take, or kill any migratory game bird on, from, or across any graded paved, or maintained public road and including the areas lying within right-of-way fences or 40 feet from the edge of the pavement or maintained surface, in absence of right-of-way fences.

(2) Vehicles, boats, aircraft: It shall be unlawful to shoot at any migratory game bird from within a motor vehicle, power boat, sailboat, or aircraft. EXCEPTION - Migratory game birds may be taken from a motor-driven boat (or other craft with attached motor) or sailboat when resting at anchor or fastened within or immediately alongside a fixed hunting blind or is used solely as a means of picking up dead birds.

(3) Harassing migratory game birds: It shall be unlawful, at any time, to pursue, harass, harry, drive, or rally any migratory game bird by use of or from a motor-driven vehicle, powerboat, sailboat, or aircraft.

(4) Vehicle off of established road: During the seasons established for any migratory game bird, it shall be unlawful to drive or ride in a motor vehicle, which is driven off an established road when the vehicle bears a licensed hunter, fisherman or trapper. EXCEPTION: 1) Snowmobiles; 2) All landowners, lessees or their employees, while on their owned or leased lands in connection with legitimate agricultural activities.

(5) Closed roads: During the seasons established for any migratory game bird, it shall be unlawful to knowingly occupy, drive, or cause to be driven any motor vehicle on a closed road when the vehicle bears a licensed hunter, angler or trapper.

(6) Mobility impaired:

(a) Shooting from a vehicle: The holder of a mobility impaired card is authorized to shoot at and kill migratory game birds during their respective open seasons from a stationary motor-driven vehicle that is not on a public road or highway. The director may issue permits to shoot from a stationary vehicle to applicants who provide certification that the applicant is disabled in accordance with the American Disability Act. Such certification shall be signed by an M.D. or O.D. licensed to practice in the applicant's state of residence.

(b) Driving off established roads: Holders of a mobility impaired card may, with permission of the landowner, lessee, or land management agency, drive off established roads to hunt for or take migratory game birds, during open seasons.

(c) Assistance for mobility impaired hunter: The holder of a mobility impaired card may be accompanied by another person to assist in reducing to possession any migratory game bird which has clearly been wounded by the licensed mobility impaired hunter. Persons assisting in reducing to possession any wounded migratory game birds shall be fully licensed.

N. Lands and waters owned, administered, controlled, or managed by the state game commission:

(1) Posting of signs: The state game commission may prohibit, modify, condition, or otherwise control the use of areas under its control by posting of signs as may be required in any particular area.

(2) Violating provisions of posted signs: It shall be unlawful to violate the provisions of posted signs on areas under the

control of the state game commission.

(3) Trespass on state game commission owned lands: It shall be unlawful to hunt migratory game birds, camp, or trespass upon state game commission owned lands unless otherwise specifically allowed by rule.

(4) State waterfowl management areas and wildlife management areas open, species that can be hunted, and days open for hunting: Use of vehicles will be restricted to designated areas.

(a) The Brantley WMA (excluding the Seven Rivers waterfowl management area portion, as posted) shall be open for all migratory game bird hunting during established statewide seasons, except the old McMillan lake spillway arm of Brantley lake extending from the mouth of South Seven Rivers draw north to the railroad trestle shall be closed to all hunting from January 1 through February 28.

(b) Bernardo WMA: Those hunting waterfowl on Bernardo WMA shall have in their possession a free Bernardo/La Joya WMA permit obtained from the department website or offices.

(i) That portion of the Bernardo WMA south of US-60 is open to teal hunting each day of the September teal season and the youth waterfowl days. That portion of the Bernardo WMA north of US-60 is open to only youth hunters during each day of the September teal season and the youth waterfowl days.

(ii) That portion of Bernardo WMA east of the unit 7 drain, 600 feet south of US-60 and portions north of US-60, shall be open only on Monday, Wednesday, and Saturday to hunt ducks, geese, Virginia rail, sora, common moorhen, American coot, and common snipe during established seasons, unless otherwise specifically allowed by rule.

(iii) That portion of Bernardo WMA west of the unit 7 drain, 600 feet south of US-60 and portions north of US-60, shall be open only on Sunday and Thursday to hunt ducks, geese, Virginia rail, sora, common moorhen, American coot, and common snipe during established seasons, unless otherwise specifically allowed by rule.

(iv) Designated posted areas of Bernardo WMA north of US-60 are open during the light goose conservation order. Areas east of the unit 7 drain shall be open on Monday, Wednesday, and Saturday; areas west of the unit 7 drain shall be open on Sunday and Thursday.

(v) Designated areas open for Bernardo youth waterfowl hunts are: north of highway U.S. 60, between U.S. 60 and the posted closure areas. Areas east of the unit 7 drain shall be open on Monday, Wednesday, and Saturday; areas west of the unit 7 drain shall be open on Sunday and Thursday.

(c) The Big Hatchet mountain wildlife management area shall be open for dove hunting during established seasons.

(d) The Charette lake WMA shall be open each day of the youth waterfowl days; and on Monday, Wednesday, and Saturday to hunt ducks, geese, Virginia rail, sora, common moorhen, American coot, and common snipe during established seasons. Charette lake WMA is closed during the September teal season.

(e) The Edward Sargent, W. A. Humphries, Rio Chama, Urraca, Colin Neblett, Water canyon, Marquez, and Elliot S. Barker wildlife management areas shall be open for hunting dove and band-tailed pigeon during established seasons.

(f) The portion of Jackson lake WMA west of NM-170 shall be open on Mondays, Wednesdays, and Saturdays to hunt ducks, geese, Virginia rail, sora, common moorhen, American coot, and common snipe. The portion of Jackson lake WMA east of NM-170 shall be open to falconry only migratory game bird hunting during established seasons.

(g) The lesser prairie-chicken management areas and Sandhills prairie conservation area shall be open to hunt dove during established seasons.

(h) La Joya WMA: Those hunting waterfowl on La Joya WMA shall have in their possession a free Bernardo/La Joya WMA permit obtained from the department website or offices.

(i) The entire La Joya WMA shall be open to teal hunting each day of the September teal season and each day of the youth waterfowl days.

(ii) That portion of La Joya WMA north of the main east/west entrance road and west of the railroad tracks shall be open on Saturdays, Mondays, and Wednesdays to hunt ducks, geese, Virginia rail, sora, common moorhen, American coot, and common snipe during established seasons, unless otherwise specifically allowed by rule.

(iii) That portion of La Joya WMA south of the main east/west entrance road and west of the railroad tracks shall be open on Sundays and Thursdays to hunt ducks, geese, Virginia rail, Sora, common moorhen, American coot, and common snipe during established seasons, unless otherwise specifically allowed by rule.

(iv) That portion of La Joya WMA east of the railroad tracks shall be open to hunt dove, ducks, geese, Virginia rail, sora, common moorhen, American coot, and common snipe during established seasons.

(i) The McAllister lake WMA shall be open each day of the youth waterfowl days; and on Monday, Wednesday, and Saturday to hunt ducks, light geese, Virginia rail, sora, common moorhen, American coot, and common snipe during established seasons.

(j) The Salt Lake WMA shall be open to teal hunting each day of the September teal season and youth waterfowl days; and open on Monday, Wednesday, and Saturday for ducks, geese, Virginia rail, sora, common moorhen, American coot and common Snipe during established seasons.

(k) The Seven Rivers WMA shall be open each day of the youth waterfowl days; and for migratory game bird hunting in designated areas as posted only on Monday, Wednesday, and Saturday during established statewide seasons.

(l) The Socorro-Escondida wildlife management area shall be open for migratory game bird hunting.

(m) The Tucumcari WMA shall be open each day of the September teal and youth waterfowl days; and on Saturday, Sunday, and Wednesday to hunt ducks, geese, Virginia rail, sora, common moorhen, American coot, and common snipe during established seasons.

(n) The William S. Huey WMA shall be open for dove hunting only on Monday, Wednesday, and Saturday during established statewide seasons.

(5) The Sandia ranger district of the Cibola national forest shall be open to archery only migratory game bird hunting during established seasons.

O. Areas closed to migratory game bird hunting: The following areas shall remain closed to hunting, except as permitted by regulation.

(1) All wildlife management areas.

(2) Rio Grande wild and scenic river area.

(3) Sub-Unit 6B (Valles Caldera national preserve).

(4) Sugarite canyon state park.

(5) Valle Vidal area.

(6) The old McMillan lake spillway arm of Brantley lake extending from the mouth of South Seven Rivers draw north to the railroad trestle shall be closed to all hunting from January 1 through February 28.

(7) That portion of the stilling basin below Navajo dam lying within a line starting from N. M. 511 at the crest of the bluff west of the Navajo dam spillway and running west along the fence approximately 1/4 mile downstream, southwest along the fence to N. M. 511 to the Navajo dam spillway, across the spillway, and to the crest of the bluff.

(8) Areas within Valencia county may be closed to migratory game bird hunting that meets the following criteria:

(a) The discharge of a shotgun in the area has been identified by department personnel as a public safety risk because of

its proximity to an inhabited area. For the purpose of this section, "public safety risk" shall be defined as a reasonable potential risk of injury at an occupied place of residence; and

(b) The discharge of a shotgun in the area is not prohibited by any other statute, rule, regulation or ordinance.

(c) These areas shall be designated by posting of signs and identified on the department website.

P. Regulations pertaining to boats, other floating devices, and motors:

(1) On Bernardo, La Joya, Salt lake and Jackson lake WMAs only boats and other floating devices using no motors shall be permitted during waterfowl season**.**

(2) On Tucumcari WMA, only boats and other floating devices using electric motors or with motors that are not in use shall be permitted.

(3) On Charette and McAllister lakes boats and other floating devices with or without motors shall be permitted; provided, however, that boats or floating devices shall not be operated at greater than normal trolling speed.

(4) Department of game and fish personnel or persons authorized by the director may use gasoline powered outboard motors on all lakes mentioned in this chapter while performing official duties.

Q. Electronic motion decoys: It shall be unlawful to use electronic motion decoys while hunting waterfowl on those portions of Bernardo WMA, north of US highway 60.

[19.31.6.9 NMAC - Rp, 19.31.6.9 NMAC, 8-31-2009]

19.31.6.10 SPECIES, OPEN AREAS, SEASON DATES, AND DAILY BAG LIMITS:

A. 2009-2010 season; all dates are 2009 unless otherwise specified:

SPECIES	OPEN AREAS	SEASON OPEN	DAILY BAG LIMIT
Dove: Mourning and white-winged dove	north zone	Sept. 1-Nov. 9	15 (singly or in aggregate)
	south zone	Sept. 1-Oct. 9 & Dec. 1-31	15 (singly or in aggregate)
Eurasian-collared dove	statewide	Sept. 1-Dec. 31	no bag or possession limit
Band-tailed pigeon	southwest BPHA	Oct. 1-20	5
(free permit required)	regular BPHA	Sept. 1-20	5
Sandhill crane (free permit required)	eastern	Oct. 31- Jan. 31, 2010	3
Sandhill crane	MRGV	Oct. 31- Nov. 1	3 (6 per season)
(special draw permit required)	EV	Oct. 31 - Nov. 8	3
	SW	Oct. 31 - Nov. 8	3
	MRGV	Nov. 21-22	3 (6 per season)
	MRGV	Dec. 5-6	3 (6 per season)
	SW	Jan. 2-3, 2010	3 (6 per season)
	MRGV	Jan. 9-10, 2010	3 (6 per season)
	MRGV youth-only	Nov. 14	3 (possession-6, regular and special seasons combined)

CENTRAL FLYWAY

SPECIES	SEASON DATES	DAILY BAG LIMIT
September teal: blue-winged teal, green-winged teal, and cinnamon teal	Sept. 19-27	4 (singly or in the aggregate)
Youth waterfowl days: north zone	Oct. 3-4	6 (singly or in the aggregate) -- that consists of no more than 5 mallard (of which only 2 may be female mallard, [Mexican-like ducks are included towards the mallard bag limit]), 3 wood duck, 2 redhead, 2 hooded mergansers, 2 scaup, 1 pintail, 1 canvasback
Youth waterfowl days: south zone	Oct. 17-18	same as north zone

Ducks: north zone	Oct. 10 - Jan. 13, 2010	6 (singly or in the aggregate) -- that consists of no more than 5 mallard (of which only 2 may be female mallard, [Mexican-like ducks are included towards the mallard bag limit]); 3 wood duck; 2 redhead; 2 hooded mergansers; 2 scaup, 1 pintail, and 1 canvasback
south zone	Oct. 28 - Jan. 31, 2010	same as north zone
American coot	same as above zone dates	15
Common moorhen	Oct. 3 - Dec. 11	1
Common snipe	Oct. 17 - Jan. 31, 2010	8
Virginia rail & sora	Sept. 19 - Nov. 27	10 daily (singly or in the aggregate)
Dark goose: Canada & white-fronted geese (regular season closed in Bernalillo, Sandoval, Sierra, Socorro, and Valencia counties)	Oct. 17 - Jan. 31, 2010	4
Special MRGV season (free permit required)	Jan. 2 - Jan. 24, 2010	1 (1 per season)
Light goose: Ross's & snow geese	Oct. 17 - Jan. 31, 2010	20/80 possession
Light goose conservation order	Feb. 1, 2010 - Mar. 10, 2010	no bag or possession limit

PACIFIC FLYWAY

SPECIES	**SEASON DATES**	**DAILY BAG LIMIT**
Youth waterfowl days	Oct. 10-11	same as regular season below including scaup
Ducks:	Oct. 19 - Jan. 31, 2010	7 (singly or in the aggregate)-- that consists of no more than 2 female mallard, 2 redhead, 1 pintail, 1 canvasback
scaup	Nov. 07 - Jan. 31, 2010	2 daily
American coot & common moorhen	Oct. 19 - Jan. 31, 2010	12 daily (singly or in the aggregate)
Common snipe	Oct. 17 - Jan. 31, 2010	8
Virginia rail & sora	Sept. 19 - Nov. 27	10 daily (singly or in the aggregate)
Goose: north zone	Sept. 19 - Oct. 4 and Nov. 2 - Jan. 31, 2010	3 dark geese, 10 light geese

south zone	Oct. 17 - Jan. 31, 2010	2 dark geese, 10 light geese

B. Light goose conservation measures: Under the director's discretion with the verbal concurrence of the state game commission chairman or his designee, the department may implement the light goose conservation measures approved by the U.S. fish and wildlife service (USFWS). Methods, bag and possession limits, and dates allowed shall be those as approved by the USFWS. A free permit is required.

[19.31.6.10 NMAC - Rp, 19.31.6.10 NMAC, 8-31-2009]

19.31.6.11 FALCONRY SEASONS:

A. Species that can be taken, open areas, and hunting seasons; 2009-2010 season, all dates are 2009 unless otherwise specified:

(1) The season for dove shall be statewide and shall be open September 1 through November 12 and November 28 through December 31.

(2) The season for band-tailed pigeon shall be September 1 through December 16 for the regular hunting area and October 1 through January 15, 2010 for the southwest hunting area. A free permit is required.

(3) The season for sandhill crane shall be in the eastern New Mexico sandhill crane hunt area and shall be open from October 17 through January 31, 2010. A free permit is required.

(4) The season for sandhill crane in the Estancia valley shall be October 31 through December 29. A special season permit is required.

(5) Duck and Coot: Central flyway seasons shall be open in the North zone - September 19-27, October 3-4, and October 10 through January 13, 2010; South zone - September 19-27, October 17-18, and October 28 through January 31, 2010. Pacific flyway seasons shall be as follows: October 10-11, and October 19 through January 31, 2010.

(6) Light goose: Central flyway seasons shall be open October 17 through January 31, 2010. Pacific flyway season shall be north zone - September 19 through October 4, and November 2 through January 31, 2010; south zone - October 17 through January 31, 2010.

(7) Dark goose: Central flyway seasons shall be open October 17 through January 31, 2010. Pacific flyway season shall be north zone - September 19 through October 4, and November 2 through January 31, 2010; south zone - October 17 through January 31, 2010.

(8) Common snipe: Central and Pacific flyways seasons shall be: October 17 through January 31, 2010.

(9) Common moorhen: Central flyway season shall be: October 3 through January 17, 2010. Pacific flyway season shall be: October 17 through January 31, 2010.

(10) Sora and Virginia rails: Central and Pacific flyways seasons shall be: September 19 through January 3, 2010.

B. Daily bag limits: shall be three birds (singly or in the aggregate) and possession limits shall be six birds (singly or in the aggregate) as established herein.

(1) There is no daily bag or possession limit on Eurasian-collared dove.

(2) Season limit for sandhill crane in the Estancia valley shall be 9 birds.

[19.31.6.11 NMAC - Rp, 19.31.6.11 NMAC, 8-31-2009]

19.31.6.12 REQUIREMENTS AND PERMITS FOR BERNARDO LIGHT GOOSE HUNT:

A. Up to 24 permits at Bernardo WMA, per hunting day, will be available. Applications submitted for the LTG-O-102 hunt must have a minimum of one youth hunter and one hunter over 18 years of age.

B. Hunt packages for the Bernardo light goose hunts.

LTG-O-101 12/31
LTG-O-102 1/23/2010
LTG-O-103 1/25/2010

C. Only 30 rounds per hunter will be allowed at the blinds when participating on the Bernardo WMA light goose special permit hunts.

[19.31.6.12 NMAC - Rp, 19.31.6.12 NMAC, 8-31-2009]

19.31.6.13 REQUIREMENTS AND PERMITS FOR BERNARDO YOUTH-ONLY LIGHT GOOSE HUNT:

A. Up to 12 permits will be available for the December 29 (YLG-O-101) youth-only light goose hunt at Bernardo WMA.

B. Only 30 rounds per hunter will be allowed at the blinds when participating on the Bernardo WMA light goose special permit hunts.

[19.31.6.13 NMAC - Rp, 19.31.6.13 NMAC, 8-31-2009]

19.31.6.14 REQUIREMENTS AND PERMITS FOR THE SPECIAL MIDDLE RIO GRANDE VALLEY DARK GOOSE SEASON: Unlimited permits obtained at department offices or website will be available to hunt dark geese in Valencia, Socorro, and Sierra counties, with a daily bag limit of two dark geese and a season limit of two dark geese.

[19.31.6.14 NMAC - Rp, 19.31.6.14 NMAC, 8-31-2009]

19.31.6.15 YOUTH WATERFOWL HUNTING DAYS: Requirements for youth hunters to participate in this hunt are as follows:

A. Youth hunters must be under 16 years old.

B. An adult, at least 18 years old, must accompany the youth hunter in the field (the adult may not hunt ducks; but may participate in other seasons that are open on the special youth day).

C. Only ducks and coots may be taken by the youth hunter (sandhill cranes, geese or any other migratory game bird species may not be taken unless the season is open).

[19.31.6.15 NMAC - Rp, 19.31.6.17 NMAC, 8-31-2009]

19.31.6.16 REQUIREMENTS AND HUNT CODES FOR THE SPECIAL BERNARDO YOUTH WATERFOWL HUNT AREA:

A. The Bernardo WMA ponds north of highway U.S. 60 will be open for waterfowl hunting to groups consisting of a minimum of a youth hunter, under 18 years of age, and a supervising adult.

B. Requirements for blind selection:

(1) Blind selection during the September teal season and federal youth waterfowl days including weekends is on a first come basis. Once all blinds are selected, no other hunters may enter the area.

(2) Blind selection on weekdays between October 28 through December 17 and January 4-31, 2010 is on a first come basis. Once all blinds are selected, no other hunters may enter the area.

(3) Blind selection on all weekends and weekdays between December 19 through January 3, 2010 will be available by permit only issued by drawing.

(a) up to two hunt choices may be awarded by drawing; and

(b) if any permits are available after the drawing, a person may submit a new application at one of the department offices; up to 2 hunt choices may be awarded; hunters may have a maximum of 4 Bernardo youth-only permits per license year; and

(c) only two applications per hunt code will be drawn, or issued after the drawing.

C. 2009-2010 season, hunt codes and permits available:

Hunt Date	Hunt Code	No. of permits		Hunt Date	Hunt Code	No. of permits
October 31	BNY-0-101	6		December 24	BNY-0-120	6
November 1	BNY-0-102	6		December 25	BNY-0-121	6
November 7	BNY-0-103	6		December 26	BNY-0-122	6
November 8	BNY-0-104	6		December 27	BNY-0-123	6
November 14	BNY-0-105	6		December 28	BNY-0-124	6
November 15	BNY-0-106	6		December 29	BNY-0-125	6
November 21	BNY-0-107	6		December 30	BNY-0-126	6
November 22	BNY-0-108	6		December 31	BNY-0-127	6
November 28	BNY-0-109	6		January 1	BNY-0-128	6
November 29	BNY-0-110	6		January 2	BNY-0-129	6
December 5	BNY-0-111	6		January 3	BNY-0-130	6
December 6	BNY-0-112	6		January 9	BNY-0-131	6
December 12	BNY-0-113	6		January 10	BNY-0-132	6
December 13	BNY-0-114	6		January 16	BNY-0-133	6
December 19	BNY-0-115	6		January 17	BNY-0-134	6
December 20	BNY-0-116	6		January 23	BNY-0-135	6
December 21	BNY-0-117	6		January 24	BNY-0-136	6
December 22	BNY-0-118	6		January 30	BNY-0-137	6
December 23	BNY-0-119	6		January 31	BNY-0-138	6

D. Designated areas open for Bernardo youth waterfowl hunts are: north of highway U.S. 60, between U.S. 60 and the posted closure areas.

(1) That portion of Bernardo WMA east of the unit 7 drain, shall be open only on Monday, Wednesday, and Saturday to hunt ducks, geese, Virginia rail, sora, common moorhen, American coot, and common snipe during established seasons.

(2) That portion of Bernardo WMA west of the unit 7 drain, shall be open only on Sunday and Thursday to hunt ducks, geese, Virginia rail, sora, common moorhen, American coot, and common snipe during established seasons.

E. Use of motorized motion decoys is prohibited.

[19.31.6.16 NMAC - Rp, 19.31.6.16 NMAC, 8-31-2009]

[*Continued on page 1082*]

19.31.6.17 HUNT CODES AND PERMITS NUMBERS FOR THE SPECIAL ESTANCIA VALLEY, MIDDLE RIO GRANDE VALLEY, AND SOUTHWEST NEW MEXICO SANDHILL CRANE SEASONS:

A. Nine separate sandhill crane seasons are scheduled with up to a total of 524 permits available. The permits will be allocated by season as follows: 2009-2010 season:

Season Dates	Hunt Code	Hunt Location	No. of permits
October 31- November 1	SCR-0-101	MRGV	80
October 31- November 8	SCR-0-102	EV	60
November 21-22	SCR-0-103	MRGV	75
December 5-6	SCR-0-104	MRGV	75
October 31- November 8	SCR-0-105	SW	70
January 9-10, 2010	SCR-0-106	MRGV	75
January 2-3, 2010	SCR-0-107	SW	60
October 31 though December 29	SCR-6-108	EV falconry	5
November 14	SCR-0-109	MRGV youth	24

B. Hunters who participate in the MRGV seasons shall be required to check-out at designated check stations when they harvest any sandhill cranes. Those hunters participating in the southwest seasons will be requested to check-out at designated check stations at the end of each hunt date.

C. All EV, MRGV, SW sandhill crane hunters, and EV falconers are required to submit a special permit sandhill crane harvest report to the department within 5 days after the end of their hunt. Hunters and falconers that do not submit a questionnaire within five days of the close of their hunt will be considered ineligible to receive a sandhill crane permit the following year.

[19.31.6.17 NMAC - N, 8-31-2009]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.307.1 NMAC, sections 6, 7 and 8, effective September 1, 2009.

8.307.1.6 OBJECTIVE: The objective of these [~~regulations~~] rules is to provide policies for the service portion of the New Mexico medicaid [~~coordinated~~] coordination of long-term services program.

[8.307.1.6 NMAC - N, 8-1-08; A, 9-1-09]

8.307.1.7 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 [~~coordinated~~] coordination of long-term services program has been implemented. This section contains the glossary for the New Mexico medicaid [~~coordinated~~] coordination of long-term services 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) **Activities of daily living:** Activities necessary for daily living, including eating, dressing, oral hygiene, bathing, mobility, toileting, grooming, taking medications, transferring from a bed or chair, and walking, consistent with NMSA 1978 Section 28-17-3

(4) **Advance directive:** Written instructions relating to the provision of health services when an adult is incapacitated. May include an advance directive, mental health advance directive, living will, durable health care power of attorney, durable mental health care power of attorney, or advance health directive. See generally NMSA 1978 Sections 27-7A-1 to 27-7A-18 and Sections 24-7B-1 to 27-7B-16.

(5) **Adverse determination:** A determination by [~~coordinated~~] coordination of long-term services managed care organization [~~(CLTS MCO)~~](CoLTS MCO)/single statewide entity (SE), or by its utilization review agent, that the health care services furnished or proposed to be furnished to a member are not medically necessary or are not appropriate.

(6) **ALTSD:** The New Mexico aging and long-term services department.

(7) **Appeal, member:** A request from a member or provider, on the member's behalf with the member's written permission, for review by the [~~coordinated~~] coordination of long-term services managed care organization [~~(CLTS MCO)~~] (CoLTS MCO) or the single statewide entity (SE) for behavioral health of a [~~CLTS MCO/SE~~] CoLTS MCO/SE action as defined above in Paragraph (2) of Subsection A of 8.307.1.7 NMAC, *action.*

(8) **Appeal, provider:** A request by a provider for a review by a [~~CLTS MCO/SE of a CLTS MCO/SE~~] CoLTS MCO/SE of a CoLTS MCO/SE action related to the denial of payment or an administrative denial.

(9) **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.

(10) **Assignment algorithm:** Predetermined method for assigning mandatory enrollees who do not select a [~~CLTS~~] CoLTS MCO.

(11) **Assisted living services:** Residential services that include personal support services, companion services, and assistance with medication administration, as set forth in department of health rules 7.8.2 NMAC, *Residential Health Facilities.*

(12) **At risk:** The period of time that a member is enrolled with a [~~CLTS MCO/SE~~] CoLTS MCO/SE, during which the [~~CLTS MCO/SE~~] CoLTS MCO/SE is responsible for providing covered services under capitation.

B. Definitions beginning with letter "B":

(1) **Begin date:** The first day of the first full month following selection

of or assignment to a [~~CLTS MCO SE~~] CoLTS MCO/SE. For members who are in a nursing facility prior to the level of care determination but not enrolled in medicaid or medicare managed care, the begin date will be the first of the month in which both nursing facility level of care and medicaid eligibility exists.

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

(3) **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

(4) **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.

(5) **Benefit package:** Medicaid covered services that must be furnished by the [~~CLTS MCO/SE~~] CoLTS 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 a [~~CLTS MCO/SE~~] CoLTS 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) **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.

(3) **Case management for physical health:** The targeted case management programs that are part of the medicaid benefit package. 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; and coordinate, advocate for and link members to all needed services related to the targeted case management program.

(4) **Claim:** A bill for services, a line item of service, or all services for one member within a bill.

(5) **Claim dispute:** A dispute, filed by a [~~CLTS MCO/SE~~] CoLTS MCO/SE or a service provider, involving payment of a claim, denial of a claim, or imposition of a sanction.

(6) **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.

(7) **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".

(8) [**~~CLTS MCO/SE~~**] **CoLTS MCO/SE:** [~~The use of CLTS MCO/SE in these coordinated long-term services regulations indicates the following regulation applies to both the CLTS MCO and the SE, who must each comply with the regulation independent of each other.~~] The use of CoLTS MCO/SE in these coordinated long-term services rules indicates the following rule applies to both the CoLTS MCO and the SE, who must each comply with the rule independent of each other.

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

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

(11) **Complaint:** An expression of dissatisfaction expressed by a complainant, orally or in writing, to the [~~CLTS MCO/SE~~] CoLTS MCO/SE or to HSD or its designee about any matter related to the [~~CLTS MCO/SE~~] CoLTS MCO/SE other than an action. Possible subjects for complaints include, but are not limited to, the quality of care or services provided; aspects of interpersonal relationships, such as rudeness of a service provider or employee; or failure to respect a member's rights.

(12) **Comprehensive community support services (CCSS):** 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) **Concurrent review:** A process of updating clinical information from a service provider to a [~~CLTS MCO/SE~~] CoLTS MCO/SE regarding a member who is already receiving a covered service, to evaluate whether the service continues to be medically necessary.

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

(15) **Member direction:** The ability of a member to be actively involved in and in control of, to the extent possible, all aspects of the member's individual service plan (ISP); to identify and include others in the ISP planning process; and to hire and direct personal assistance services, as applicable.

(16) **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 modifications of improvements, as indicated.

(17) [**~~Coordinated~~**] **Coordination of long-term services:** 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.

(18) **Copayment:** A monetary amount specified by the state that the member pays directly to the [~~CLTS MCO/SE~~] CoLTS MCO/SE or to a service provider at the time that covered services are rendered.

(19) **Critical incident:** A reportable incident that may include, but is not limited to, abuse, neglect or exploitation; death; environmental hazards; law enforcement intervention; or emergency services, and which encompasses the full range of physical health, medicaid state plan, and home and community-based services.

(20) **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 to increase the quality and appropriateness of health care and outcomes.

D. Definitions beginning with letter "D":

(1) **Delegation:** A formal process by which a [~~CLTS MCO/SE~~] CoLTS MCO/SE gives another entity the authority to perform certain functions on its behalf. The [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE formulary or due to provider noncompliance with administrative policies and procedures established by either the [~~CLTS MCO/SE~~] CoLTS 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 processes, collaborative practice models, patient self-management education processes, evidence-based practice guidelines, process and outcome measurements, and internal quality improvement processes.

(5) **Disenrollment, [~~CLTS MCO~~] CoLTS MCO initiated:** When requested by a [~~CLTS MCO~~] CoLTS MCO for substantial reason, removal of a medicaid member from membership in the requesting [~~CLTS MCO~~] CoLTS 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 [~~CLTS MCO~~] CoLTS MCO to a different [~~CLTS MCO~~] CoLTS 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 a [~~CLTS MCO/SE~~] CoLTS MCO/SE member, client, customer, or consumer.

(3) **Encounter data:** Data elements from encounters for fee-for-service or capitated service proxy claims. Encounter data elements are a combination of those elements required by HIPAA-compliant transaction formats that comprise a minimum core data set.

(4) **Enrollee:** A medicaid participant who is currently enrolled in a [~~CLTS MCO/SE in a~~] CoLTS MCO/SE coordinated long-term services program.

(5) **Enrollee rights**: Rights that each [~~coordinated~~] coordination of long-term services enrollee is guaranteed.

(6) **Enrollment:** The process of enrolling eligible clients in a [~~CLTS MCO/SE~~] CoLTS MCO/SE for purposes of management and coordination of health service delivery.

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

(8) **Exemption:** Removal of a medicaid member from mandatory enrollment in [~~coordinated~~] coordination of long-term services, 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE of a [~~CLTS MCO/SE~~] CoLTS 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 the 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~~] 8.325.3 NMAC [MAD 762], *Reproductive Health Services*).

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

(4) **Federally qualified health center (FQHC):** An entity that meets the requirements and receives a grant and funding pursuant to Section 330 of the Public Health Service Act. An FQHC may include an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (PL 93-638), or an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.

(5) **Fraud:** An intentional deception or misrepresentation made by an entity or person, including but not limited to, a [~~CLTS MCO/SE~~] CoLTS 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.

(6) **Full benefit dual eligible:** An individual enrolled in medicare and eligible for full medicaid benefits, not limited to covering costs, such as medicare premiums.

(7) **Full risk contracts:** Contracts that place the [~~CLTS MCO/SE~~] CoLTS MCO/SE at risk for furnishing or arranging for comprehensive services.

G. Definitions beginning with letter "G":

(1) **Gag order:** Subcontract provisions or [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE or its business practices.

(2) **Grievance, member:** An oral or written statement by a member expressing dissatisfaction with any aspect of a [~~CLTS MCO/SE~~] CoLTS MCO/SE or its operations that is not a [~~CLTS MCO/SE~~] CoLTS MCO/SE action.

(3) **Grievance, provider:** An oral or written statement by a provider to the [~~CLTS MCO/SE~~] CoLTS MCO/SE expressing dissatisfaction with any aspect of a [~~CLTS MCO/SE~~] CoLTS MCO/SE or its operations that is not a [~~CLTS MCO/SE~~] CoLTS 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) **Hearing or fair hearing:** An administrative hearing that is held so that evidence may be presented. (See 8.352.2 NMAC, *Recipient Hearings*.)

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

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

(6) **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 [~~CLTS MCO/SE~~] CoLTS MCO/SE has incurred financial liability, but the claim has not been received by the [~~CLTS MCO/SE~~] CoLTS MCO/SE. This estimating method relies on data from prior authorization and referral systems, other data analysis systems and accepted accounting practices.

(2) **Individualized service plan (ISP):** An individualized service plan developed with and for members who have chronic or complex conditions, and with others involved in the member's services, to improve functional outcomes, including the standards in 8.314.2.15 NMAC, *individualized service plan*. An ISP includes, but is not limited to: a member's history; a summary of current medical and social needs and concerns; short and long-term service needs and goals; a list of services required and their frequency; and a description of who will provide the services. An ISP must be in accordance with the approved CMS [~~coordinated~~] coordination of long-term services home and community-based waiver program and New Mexico medicaid state plan.

(3) **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 related services of a type or amount beyond that required by individuals generally.

J - K. [RESERVED]

L. Definitions beginning with letter "L": **Long-term services:** A continuum of services and supports, ranging from in-home and community-based services for the elderly and individuals with disabilities who need help in maintaining their independence, to institutional services for those who require an institutional level of support. Throughout the continuum of long-term services and supports, the goal is to provide needed services and supports to the member while striving to maintain the member's independence to the greatest extent possible.

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 materials include brochures, leaflets, internet, newspaper, magazine, radio, television, billboard materials, yellow page advertisements, and any other presentation materials used by a [~~CLTS MCO/SE~~] CoLTS MCO/SE, [~~CLTS MCO/SE~~] CoLTS MCO/SE representative, or [~~CLTS MCO/SE~~] CoLTS MCO/SE subcontractor to attract or retain medicaid 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) **Medical/clinical home:** A conceptual model that facilitates the provision of quality care that is accessible, family-centered, continuous, coordinated, compassionate and culturally competent.

(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 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 [~~CLTS MCO/SE~~] CoLTS 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.

(6) **Member:** A client enrolled in a [~~CLTS MCO/SE~~] CoLTS MCO/SE.

(7) **Member month:** A calendar month during which a member is enrolled in a [~~CLTS MCO/SE~~] CoLTS MCO/SE.

(8) **Mi via home and community-based waiver:** The mi via waiver provides self-directed home and community based services to eligible HCBS waiver recipients who are disabled or elderly (D&E), developmentally disabled (DD), medically fragile (MF), those diagnosed with acquired immunodeficiency syndrome (AIDS), and those diagnosed with certain brain injuries (BI).

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 a [~~CLTS MCO/SE~~] CoLTS MCO/SE to furnish medical or behavioral health services to the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's members under the provisions of the medicaid [~~coordinated~~] coordination of long-term services contract.

(3) **Non-contracted provider (non-network provider):** An individual service provider, clinic, group, association or facility that provides covered services but does not have a contract with the [~~CLTS MCO/SE~~] CoLTS MCO/SE.

(4) **Nursing facility:** A medicare/medicaid facility licensed and certified in accordance with 42 CFR 483 to provide inpatient room, board and nursing services to members who require these services on a continuous basis but who do not require hospital services or direct daily services from a physician.

O. [RESERVED]

P. Definitions beginning with letter "P":

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

(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 a [~~CLTS MCO/SE~~] CoLTS MCO/SE to pend approval does not extend or modify required utilization management decision timelines.

(3) **Performance improvement project (PIP):** A [~~CLTS MCO/SE~~] CoLTS 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.

(4) **Performance measurement (PM):** Data specified by the state that enables the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's performance to be determined.

(5) **Person-centered planning:** A process through which each consumer or participant is actively engaged, to the extent that the consumer or participant desires, in identifying their needs, goals and preferences, and in developing strategies to address those needs, goals and preferences.

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

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

(8) **Post-stabilization care services:** Services related to an emergency medical condition that are provided after a member is medically stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR Section 438.114(b) and (e) and 42 CFR Section 422.113(c)(iii) to improve or resolve the member's condition.

(9) **Potential enrollee:** A medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given [~~coordinated~~] coordination of long-term services program, but is not yet a member of a specific [~~CLTS MCO/SE~~] CoLTS MCO/SE.

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

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

(12) **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.

(13) **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.

(14) **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 [~~stat~~] state option, any of the following:

(a) a physician assistant;

(b) a nurse practitioner; or

(c) a certified nurse midwife.

(15) **Primary care provider (PCP):** A provider who agrees to manage and coordinate the care provided to members in the [~~coordinated~~] coordination of long-term services program.

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

(17) **Provider lock-in, PCP lock-in:** A situation in which the [~~CLTS MCO/SE~~] CoLTS MCO/SE requires that a member see a specific identified network provider, while ensuring reasonable access to additional services, when the [~~CLTS MCO/SE~~] CoLTS MCO/SE identifies utilization of unnecessary services or when a member's behavior is detrimental or indicates a need to provide case continuity.

Q. Definitions beginning with letter "Q": **Quality assurance:** A process that is adopted by a health services entity that follows written standards and criteria. The process includes the activities of a health services entity or any of its committees that: investigate the quality of health services through the review of professional practices, home and community-based service provider practices, training and experience; investigate patient cases or conduct of licensed health service providers; or encourage proper utilization of health care services and facilities. Quality assurance follows a process of discovery, both prospective and retrospective to evaluate the program; identifies areas for remediation; and implements quality improvement strategies to ensure that appropriate and timely action is taken, as indicated.

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 [~~CLTS MCO/SE~~] CoLTS MCO/SE but not paid, affecting appropriate expense and aging accounting categories. Such claims are counted as of the date of receipt by the [~~CLTS MCO/SE~~] CoLTS 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) or long-term services 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 a [~~CLTS MCO/SE~~] CoLTS 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 a [~~CLTS MCO/SE~~] CoLTS MCO/SE will not be sufficient to cover expenditures incurred in the delivery of contractual services.

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

S. Definitions beginning with letter "S":

(1) **Salud!:** The New Mexico

physical health managed care program implemented in 1997, covering children, families, pregnant women and disabled New Mexicans. Parents of medicaid-eligible children were also covered by medicaid if they met eligibility requirements.

[~~(1)~~] (2) S**ervice coordination:** A specialized service management that is performed by a service coordinator, in collaboration with the member or the member's family or representatives as appropriate, that is person-centered, and that includes, but is not limited to: (a) identification of the member's needs, including physical health services, mental health services, social services, and long-term support services; and development of the member's ISP or treatment plan to address those needs; (b) assistance to ensure timely and coordinated access to an array of providers and services; (c) attention to addressing unique needs of members; and (d) coordination with other services delivered outside the ISP, as necessary and appropriate. Service coordination operates independently within the [~~CLTS MCO/SE~~] CoLTS MCO/SE using recognized professional standards adopted by the [~~CLTS MCO/SE~~] CoLTS MCO/SE and approved by the state, based on the service coordinator's independent judgment to support the needs of the member and is structurally linked to the other [~~CLTS MCO/SE~~] CoLTS MCO/SE systems, such as quality assurance, member services and grievances. Clinical and other decisions shall be based on medical necessity and not on fiscal considerations.

[~~(2)~~] (3) **Service coordinator:** An employee or subcontractor of the [~~CLTS MCO/SE~~] CoLTS MCO/SE with primary responsibility for providing service coordination/management to members who have complex care needs including long-term service and supports or needs, or who otherwise want assistance with service planning. The service coordinator need not be a medical professional.

[~~(3)~~] (4) **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 proposals (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 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 [~~to~~] so as to increase flexibility, maximize available resources and create a seamless single behavioral health service delivery system for New Mexico.

[~~(4)~~] (5) **Special needs individual:** A medicare advantage (MA) eligible individual who is institutionalized, is entitled to medical assistance under a state plan under Title XIX, or has a severe or disabling chronic condition(s) and would benefit from enrollment in a specialized MA plan.

[~~(5)~~] (6) **Special needs plan:** A specialized MA coordinated service plan for special needs individuals that exclusively or disproportionately serves special needs individuals.

[~~(6)~~] (7) **State plan:** A statewide plan for medicaid services submitted for approval to CMS under Title XIX of the federal Social Security Act.

[~~(7)~~] (8) **Subcontract:** A written agreement between a [~~CLTS MCO/SE~~] CoLTS MCO/SE and a third party, or between a subcontractor and another subcontractor, to provide services.

[~~(8)~~] (9) **Subcontractor:** A third party who contracts with a [~~CLTS MCO/SE~~] CoLTS MCO/SE or a [~~CLTS MCO/SE~~] CoLTS MCO/SE subcontractor for the provision of services.

[~~(9)~~] (10) **Suspension or suspended provider:** A service provider that has been convicted of a program-related offense in a federal, state or local court. Items or services furnished by a suspended provider will not be reimbursed under medicaid.

T. Definitions beginning with letter "T":

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

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

(3) **Tribal facility 638:** A facility operated by a Native American or Indian tribe authorized to provide services pursuant to the Indian Self-Determination and Education Assistance Act.

(4) **Tribal provider or Indian health service (IHS) provider:** A facility that is operated by a Native American/Alaskan Indian tribe authorized to provide services as defined in the Health Care Improvement Act, 25 USC Section 1601, et seq.

U. Definitions beginning with letter "U":

(1) **Urgent condition:** Acute signs and symptoms that, 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.

(2) **Utilization management:** A system for reviewing the appropriate and efficient allocation of health care services given or proposed to be given to a member.

V. Definitions beginning with letter "V": **Value-added service:** Any service or benefit offered by the [~~CLTS MCO/SE~~] CoLTS MCO/SE that is not included in the [~~coordinated~~] coordination of long-term services benefit package and is not a medicaid funded service, benefit or entitlement under the New Mexico Public Assistance Act.

W. Definitions beginning with letter "W": **Waiver program:** One or more of the state of New Mexico medicaid home and community-based services waiver programs.

X - Z. [RESERVED]

[8.307.1.7 NMAC - N, 8-1-08; A, 9-1-09]

8.307.1.8 M I S S I O N 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.
[8.307.1.8 NMAC - N, 8-1-08; A, 9-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.307.2 NMAC, sections 6, 8 and 9, effective September 1, 2009.

8.307.2.6 OBJECTIVE: The objective of these [~~regulations~~] rules is to provide policies for the service portion of the New Mexico medicaid [~~coordinated~~] coordination of long-term services program.
[8.307.2.6 NMAC - N, 8-1-08; A, 9-1-09]

8.307.2.8 M I S S I O N 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.

[8.307.2.8 NMAC - N, 8-1-08; A, 9-1-09]

8.307.2.9 MEMBER EDUCATION: Medicaid members or their legal guardian(s) shall be educated about their rights and responsibilities; service availability and administrative rules under the [~~coordinated~~] coordination of long-term services program; and the meaning of member direction and how to exercise their right to make choices about their services. Member education is initiated when a member becomes eligible for medicaid and is augmented by information provided by the human services department (HSD) or its designee and the [~~coordinated~~] coordination of long-term services managed care organization [~~(CLTS MCO)~~] (CoLTS MCO) or the single statewide entity (SE). The [~~CLTS MCO~~] CoLTS MCO shall employ sufficient staff to coordinate communication with members and perform other member services functions, including problem resolution and inquiries, as designated.

A. **Policies and procedures:** The [~~CLTS MCO~~] CoLTS MCO shall have and comply with written policies and procedures regarding the treatment of minors; adults who are in the custody of the state; children and adolescents who are under the jurisdiction of the children, youth and families department; and any individual who is unable to exercise rational judgment or give informed consent under applicable federal and state laws and regulations. The [~~CLTS MCO~~] CoLTS MCO shall maintain and comply with written policies and procedures:

(1) that describe a process to detect, measure and eliminate operational bias or discrimination against enrolled members by the [~~CLTS MCO~~] CoLTS MCO and its subcontractors;

(2) regarding the right of members or their legal guardian(s) to select a primary care provider (PCP) and to make decisions regarding needed social services and supports;

(3) governing the development and distribution of marketing materials for members;

(4) that are available to members or their representative(s), upon request, for review during normal business hours;

(5) with respect to advance directives, the [~~CLTS MCO~~] CoLTS MCO shall provide adult members with written information on advance directive policies that includes a description of applicable state laws and regulations; the information must reflect changes in state laws and regulations no later than 90 days after the effective date of such changes; and

(6) to ensure through its network providers that:

(a) written information is provided to adult members concerning their rights to accept or refuse medical or surgical treatment or home and community-based services, and to formulate advance directives; including the [~~CLTS MCO's~~] CoLTS MCO's policies and procedures with respect to the implementation of such rights;

(b) documentation exists in the member's record concerning whether or not the member has executed an advance directive;

(c) discrimination is prohibited against a member in the provision of services or based on whether the member has executed an advance directive;

(d) compliance with federal and state laws and regulations is met;

(e) education is provided for staff and the community on issues concerning advance directives; and

(f) members are informed that complaints concerning noncompliance with advance directive requirements may be filed with the state survey and certification agency, currently the department of health;

(7) to ensure provider notification to the member regarding abnormal results of diagnostic laboratory, diagnostic imaging and other testing, and, if clinically indicated, informing the member of a scheduled follow-up visit; confirmation of this shall be documented in the member's record at the service provider's office; and

(8) to ensure that its network providers and facilities are in compliance with the Americans with Disabilities Act (ADA), 42 USC Section 12101, et seq. and its regulations.

B. **Initial information:** The education of the member is initiated by the eligibility determination agencies. HSD or its designee distributes information about medicaid [~~coordinated~~] coordination of long-term services and the enrollment process to these agencies.

C. **Enrollment information:** Once a member is determined to be a [~~CLTS MCO/SE~~] CoLTS MCO/SE mandatory participant, HSD or its designee will provide the member with information about services included in the [~~CLTS MCO/SE~~] CoLTS MCO/SE benefit package and the [~~CLTS MCOs~~] CoLTS MCOs from which the member can choose to enroll as a member, including information about the member's disenrollment rights at the time of enrollment and annually thereafter.

D. **Informational materials:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE is responsible for providing members and potential members a member handbook and a provider directory within 30 calendar days of being notified of the member's enrollment, or upon request by a potential member, a member or the state. The [~~CLTS MCO/SE~~] CoLTS MCO/SE may direct a member requesting a member handbook or provider directory to an internet site, unless the member makes a specific request for a printed document. The member handbook and provider directory shall be available in formats other than English. If there is a prevalent population of five percent or more within the [~~CLTS MCO/SE~~] CoLTS MCO/SE membership, as determined by the [~~CLTS MCO/SE~~] CoLTS MCO/SE or HSD or its designee, these materials shall be made available in the language of the identified prevalent population. The state must grant prior approval of all informational materials used by the [~~CLTS MCO~~] CoLTS MCO or the SE.

(1) The [~~CLTS MCO~~] CoLTS MCO member handbook must include the following:

(a) [~~CLTS MCO/SE~~] CoLTS MCO/SE demographic information, including the organization's hotline telephone number;

(b) information on how to obtain services such as after-hour 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 regarding language accessibility;

(e) information pertaining to coordination of services by and with primary care providers (PCPs);

(f) information regarding the member's right of access to and coverage of emergency services, including the fact that the member has a right to use any hospital or other setting for emergency services; and what constitutes an emergency medical condition, emergency services, and post-stabilization services;

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

(h) information on accessing behavioral health or other specialty services;

(i) limitations on the receipt of services from out-of-network providers;

(j) list of services for which prior authorization or a referral is required and the method of obtaining both as well as clarification that prior authorization is not required for emergency services;

(k) policy on referrals for specialty services and other benefits not furnished by the member's PCP;

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

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

(n) information regarding advance health directives;

(o) information regarding obtaining a second opinion;

(p) information on cost sharing, if any;

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

(r) populations excluded from enrollment and subject to mandatory enrollment;

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

(t) the [~~CLTS MCO's~~] CoLTS MCO's policy on referrals for specialty services, long-term services and supports and other benefits; [~~and~~]

(u) language to clearly explain that a Native American member may self-refer to an Indian health service (IHS) or tribal health care facility for services; and a separate section with a listing of all IHS and tribal facilities, including hospitals, outpatient clinics, pharmacies and dental clinics; and

(v) information regarding the birthing option plan.

(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 provider;

(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; [~~and~~]

(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 CoLTS MCO member may self-refer to an Indian health service or a 638 tribal health care facility for services.

(3) The provider directory must include the following:

(a) [~~CLTS MCO/SE~~] CoLTS MCO/SE addresses and telephone numbers;

(b) CoLTS MCO: a listing of primary care and specialty providers with the identity, location, phone number, qualifications, area of special expertise, and non-English languages spoken; [~~CLTS MCO~~] CoLTS MCO contracted specialty providers for self-referral shall include, but not be limited to, [~~family planning providers~~] urgent and emergency care providers, IHS, other Native American providers, [~~and pharmacies~~] 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; and

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

E. **Other requirements:**

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

(2) A listing of all benefits, services and goods, including preventive and long-term services included in and excluded from coverage shall be made available to members in a one-page, two-sided summary format, distinguishing between services available pursuant to the state's approved section 1915(b) and section 1915(c) waivers.

(3) The [~~CLTS MCO~~] CoLTS MCO shall send out a questionnaire to all new members that must include a question regarding the new member's primary spoken or written language within 30 calendar days of enrollment.

(4) The handbook and directory shall: be provided in a comprehensive, understandable format that takes into consideration special needs populations; be written in accordance with federal mandates; and meet communication requirements delineated in 8.307.8.15 NMAC, *member bill of rights*. This information may also be accessible via the internet, and must be provided to HSD or its designee as requested.

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

(6) The handbook and directory must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. The [~~CLTS MCO~~] CoLTS MCO must have a process in place for notifying potential members and members of the availability of these alternative formats.

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

(8) Notification of material changes in the administration of the [~~CLTS MCO/SE~~] CoLTS MCO/SE, changes to the [~~CLTS MC's/SE's~~] CoLTS MCO's/SE's provider network, significant changes in applicable state law, and any other information deemed relevant by HSD or its designee shall be distributed to the [~~CLTS MCO's~~] CoLTS MCO's members 30 days prior to the intended effective date of the change. In addition, the [~~CLTS MCO/SE~~] CoLTS 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.

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

(10) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall notify all members at least once per year of their right to request and obtain member handbooks and provider directories.

F. [~~**CLTS MCO/SE**~~] **CoLTS MCO/SE policies and procedures on member education:** The [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have written policies and procedures regarding the utilization of information on race, ethnicity, and primary language spoken by its membership.

G. **Health education:** The [~~CLTS MCO/SE~~] CoLTS 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 or its designee shall not approve health education materials. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall provide programs of wellness education, including programs provided to address the social, physical, behavioral and emotional consequences of high-risk behaviors.

H. **Maintenance of toll-free line:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE 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. [~~CLTS MCO/SE~~] CoLTS MCO/SE members may also leave voice mail messages to obtain other [~~CLTS MCO/SE~~] CoLTS MCO/SE policy information and to register grievances with the [~~CLTS MCO/SE~~] CoLTS MCO/SE. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall return the telephone call by the next business day.

I. **Member services meetings:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall meet as requested with HSD or its designee's staff for member services meetings. Member services meetings are held to plan outreach and medicaid enrollment activities and events that will be jointly conducted by the [~~CLTS MCO/SE~~] CoLTS MCO/SE and HSD or its designee's outreach staff.

[8.307.2.9 NMAC - N, 8-1-08; A, 9-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.307.3 NMAC, sections 6, 8 through 11, effective September 1, 2009.

8.307.3.6 OBJECTIVE: The objective of these [~~regulations~~] rules is to provide policies for the service portion of the New Mexico medicaid [~~coordinated~~] coordination of long-term services program.

[8.307.3.6 NMAC - N, 8-1-08; A, 9-1-09]

8.307.3.8 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.

[8.307.3.8 NMAC - N, 8-1-08; A, 9-1-09]

8.307.3.9 ELIGIBLE [~~COORDINATED~~] COORDINATION OF LONG-TERM SERVICES MANAGED CARE ORGANIZATIONS [~~(CLTS MCOs)~~] (CoLTS MCOs): The human services department (HSD) shall award risk-based contracts to [~~CLTS MCOs~~] CoLTS MCOs with statutory authority to assume risk and enter into prepaid capitation agreements that meet applicable requirements and standards delineated under state and federal law, including Title IV of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

A. **Procurement process:** HSD shall award risk-based contracts to [~~CLTS MCOs~~] CoLTS MCOs using a competitive procurement process that conforms to the terms of the New Mexico Procurement Code. Offerors must submit their responses to the request for proposals in conformity with the requirements specified in the request for proposals.

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 [~~coordinated~~] coordination of long-term services contract.

[8.307.3.9 NMAC - N, 8-1-08; A, 9-1-09]

8.307.3.10 CONTRACT MANAGEMENT: HSD, or its designee, is responsible for managing the medicaid contracts issued to the [~~CLTS MCOs/SE~~] CoLTS MCOs/SE. HSD, or its designee, shall provide the oversight and administrative functions to ensure [~~CLTS MCO~~] CoLTS MCO 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 shall provide oversight of the SE contract as it relates to medicaid behavioral health services, providers and members.

A. **General contract requirements:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall meet all specified terms of the medicaid contract with HSD as it relates to medicaid members and services and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This includes, but is not limited to, ensuring confidentiality as it relates to medical records and any other health and enrollment information that identifies a particular member. The [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE may subcontract to a qualified individual or organization the provision of services defined in the benefit package or other required [~~CLTS MCO/SE~~] CoLTS MCO/SE functions with HSD's approval. The [~~CLTS MCO~~] CoLTS MCO may not assign, transfer or delegate key management functions such as utilization review, utilization management, or service coordination without the explicit written approval of the state. The [~~CLTS MCO/SE~~] CoLTS 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 prior to issuance. The [~~CLTS MCO~~] CoLTS MCO must oversee and be held accountable for any function or responsibility, including claims submission requirements, that it delegates to any subcontractor. The [~~CLTS MCO~~] CoLTS MCO shall have policies and procedures to ensure that the subcontractor meets all standards of performance mandated by the state for the [~~coordinated~~] coordination of long-term services program, including the use of appropriately qualified staff, application of clinical practice guidelines and utilization management, reporting capability, and ensuring access to services for members. 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall maintain policies and procedures for verifying that the credentials of its service providers and subcontractors meet applicable standards. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall assure the prospective subcontractor's ability to perform the activities to be delegated.

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

(3) **Minimum requirements [~~(CLTS MCO/SE)~~] (CoLTS 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 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 CoLTS MCO/SE and the process by which the CoLTS MCO/SE evaluates the delegate;

(d) subcontracts shall identify the services to be performed by the subcontractor and the services to be performed under other subcontracts;

(e) subcontracts must describe

how members access services provided under the subcontract;

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

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

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

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

(j) subcontracts shall include a provision for the subcontractor to release any information necessary to perform any of its obligations to the [~~CLTS MCO/SE~~] CoLTS MCO/SE, and that the [~~CLTS MCO~~] CoLTS MCO shall monitor the subcontractor's performance on an ongoing basis and subject the subcontractor to formal review according to a periodic schedule;

(k) subcontractors shall accept payment from the [~~CLTS MCO/SE~~] CoLTS MCO/SE for any services included in the benefit package and cannot request payment from HSD for services performed under the subcontract;

(l) if subcontracts include primary care, long-term services, or home and community-based services, provisions for compliance with PCP requirements delineated in the [~~CLTS MCO~~] CoLTS MCO contract with HSD apply;

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

(n) 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;

(o) subcontracts shall not prohibit a service provider or other subcontractor from entering into a contractual relationship with another [~~CLTS MCO~~] CoLTS MCO;

(p) subcontracts may not include incentives or disincentives that encourage a service provider or other subcontractor not to enter into a contractual relationship with another [~~CLTS MCO~~] CoLTS MCO;

(q) subcontracts shall not contain any gag order provisions nor sanctions against service providers who assist members in accessing the grievance process or otherwise protecting the interests of members;

(r) subcontracts shall specify the timeframe for submission of encounter data to the [~~CLTS MCO/SE~~] CoLTS MCO/SE;

(s) subcontractors shall be required to perform criminal background checks on all individuals providing services under the subcontract;

(t) subcontracts shall ensure that subcontractors agree to hold harmless the state and the [~~CLTS MCO's~~] CoLTS MCO's members in the event that the [~~CLTS MCO~~] CoLTS MCO cannot or shall not pay for services performed by the subcontractor pursuant to the subcontract;

(u) subcontracts for pharmacy providers shall include a payment provision consistent with 1978 NMSA Section 59A-57-1 to 57-11, the Patient Protection Act; [~~and~~]

(v) subcontracts to entities that receive annual medicaid payments of at least $5,000,000.00 shall include detailed information regarding employee education of the New Mexico and federal False Claims Act;

(w) subcontracts shall include a provision for requiring providers to submit claims electronically; low volume or low dollar providers may have this requirement waived; and

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

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

C. **Provider incentive plans:** The [~~CLTS MCO/SE~~] CoLTS 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.

[8.307.3.10 NMAC - N, 8-1-08; A, 9-1-09]

8.307.3.11 ORGANIZATIONAL REQUIREMENTS:

A. **Organizational structure:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall provide the following information to HSD, or its designee, and updates, modifications, or amendments to HSD, or its designee, 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 [~~CLTS MCO's/SE's~~] CoLTS 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 [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's relationship with parent affiliated and related business entities including, but not limited to, subsidiaries, joint ventures or sister corporations.

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

(1) **Review of policies and procedures:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall review its policies and procedures at least every two years, unless otherwise specified herein, to ensure that they reflect 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, or its designee.

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

(3) **Business requirements:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have the administrative, information and other systems in place necessary to fulfill the terms of the medicaid [~~coordinated~~] coordination of long-term services and behavioral health contracts. Any change in identified key [~~CLTS MCO/SE~~] CoLTS MCO/SE personnel shall conform to the requirements of the [~~coordinated~~] coordination of long-term services and behavioral health contracts. The [~~CLTS MCO/SE~~] CoLTS 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 specified by HSD, or its designee.

(4) **Financial requirements:** The [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall meet additional financial requirements specified in the contract.

(5) **Member services:** The [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's policies and procedures shall be made available upon request to members or member representatives for review during normal business hours.

(6) **Consumer advisory board:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall establish their respective consumer advisory board that includes regional representation of consumers, family members, advocates and service 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 [~~CLTS MCO~~] CoLTS MCO and the SE consumer advisory boards shall interface and collaborate with one another as appropriate. The [~~CLTS MCO~~] CoLTS MCO consumer advisory board shall consist of an equitable representation of the [~~CLTS MCO's~~] CoLTS MCO's members in terms of race, gender, special populations and geographic areas of the state.

(a) The consumer advisory board members shall serve to advise the [~~CLTS MCO~~] CoLTS MCO and the SE respectively 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 as they pertain to medicaid, including [~~coordinated~~] coordination of long-term services. [~~The consumer advisory boards shall meet at least quarterly and keep a written record of meetings.~~] The [~~CLTS MCO~~] CoLTS MCO consumer advisory board shall hold quarterly centrally located meetings every year and keep a written or electronic record of all attempts to invite and include its members in its meetings. The [~~board~~] attendance roster and minutes shall be made available to HSD [~~or its designee~~], its designee, for SE meetings upon request. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall advise HSD, or its designee, 10 days in advance of meetings to be held. HSD shall attend and observe consumer advisory board meetings at its discretion.

(b) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall attend at least two statewide consumer driven or hosted meetings per year, of the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's choosing, that focus on consumer issues and needs, to ensure that members' concerns are heard and addressed.

(7) **Requirements for Native American membership:** The MCO shall identify a tribal liaison to assist the MCO with issues related to Native Americans and report such tribal liaison to HSD for approval. The MCO shall hold semi-annual meetings with Native American leadership and the minutes of such meetings shall be submitted to HSD within 30 days of such meetings.

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

(a) require plans of correction;

(b) impose directed plans of correction; and

(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 [~~CLTS MCO/SE~~] CoLTS MCO/SE, including an assessment of monetary penalties against the [~~CLTS MCO/SE~~] CoLTS 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, the severity or degree of harm posed to or incurred by members, or the integrity of the medicaid program;

(iii) penalty assessments shall range up to five percent of the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's medicaid capitation payment for the 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 [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS 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 service 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, or its designee, determines was not enrolled, or reenrolled, or whose 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 members;

(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 [~~CLTS MCO/SE~~] CoLTS MCO/SE;

(i) deny payment;

(j) assess actual damages;

(k) assess liquidated damages;

(l) remove members with third party coverage from enrollment with the [~~CLTS MCO/SE~~] CoLTS MCO/SE;

(m) allow members to terminate enrollment;

(n) suspend agreement;

(o) terminate the [~~CLTS MCO/SE~~] CoLTS MCO/SE contract;

(p) apply other sanctions and remedies specified by HSD, or its designee; and

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

(i) there is continued egregious behavior by the [~~CLTS MCO/SE~~] CoLTS 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 the health and safety of the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's members; or

(iii) the sanction is necessary to ensure the health and safety of the [~~CLTS MCO's/SE's~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE.

C. 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE can ensure that the sanctioned behavior will not reoccur. Refer to state and federal regulations for due process procedures.

[8.307.3.11 NMAC - N, 8-1-08; A, 9-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.307.4 NMAC, sections 6, 8 through 11, effective September 1, 2009.

8.307.4.6 OBJECTIVE: The objective of these [~~regulations~~] rules is to provide policies for the service portion of the New Mexico medicaid [~~oordinated~~] coordination of long-term services program.

[8.307.4.6 NMAC - N, 8-1-08; A, 9-1-09]

8.307.4.8 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.

[8.307.4.8 NMAC - N, 8-1-08; A, 9-1-09]

8.307.4.9 [~~COORDINATED~~] COORDINATION OF LONG-TERM SERVICES ELIGIBILITY: The human services department (HSD) or its designee determines eligibility for enrollment in the [~~coordinated~~] coordination of long-term services program.

A. **Included populations:** Populations included in the [~~coordinated~~] coordination of long-term services program are:

(1) individuals eligible for both medicare and full benefit medicaid (dual eligibles);

(2) medicaid-eligible members residing in a nursing facility;

(3) individuals currently receiving, or who qualify for, disabled and elderly (D&E) home and community-based waiver services (COE 91, 93, and 94); and individuals with certain types of brain injury (COE 92)

(4) individuals 21 years of age or older who receive or who qualify for medicaid state plan personal care option (PCO) services; [~~and~~]

(5) individuals in the mi via 1915 (c) waiver who meet current disabled and elderly (COE 91, 93 and 94) or brain injury (COE 92) categories of eligibility; the [~~CLTS MCO/SE~~] CoLTS MCO/SE will only be at risk and financially responsible for the 1915(b) waiver services for these individuals; the individuals will self-direct any 1915(c) waiver services; and

(6) certain women eligible for medicaid category 035 (pregnancy related).

B. **Excluded populations:** Populations excluded from the [~~coordinated~~] coordination of long-term services program are:

(1) consumers residing in intermediate care facilities for the mentally retarded;

(2) consumers receiving services under 1915(c) home and community-based waiver programs for the developmentally disabled, HIV/AIDS and medically fragile;

(3) consumers participating in Salud!;

(4) consumers eligible for medicaid category 029 or [~~035, family planning or pregnancy-related~~] family planning services;

(5) women eligible for medicaid category 052, breast and cervical cancer program; and

(6) adults ages 19-64 eligible for category 062, state coverage insurance.

C. The state, or its designee, shall further determine eligibility for [~~CLTS~~] CoLTS 1915(c) home and community-based waiver services through an allocation process.

[8.307.4.9 NMAC - N, 8-1-08; A, 9-1-09]

8.307.4.10 SPECIAL SITUATIONS:

A. **Hospitalized members:** [~~If a CLTS member is hospitalized at the time of disenrollment from the coordinated long-term services program or an approved switch to another CLTS MCO, the CLTS MCO shall be responsible until the date of discharge for payment for all covered facility and professional services provided within a licensed acute care facility or non-psychiatric specialty unit as designated by the New Mexico department of health. The payer at the date of hospital admission (coordinated long-term services or medicaid fee-for-service) remains responsible for 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. Transition services (e.g., durable medical equipment supplies for the home) shall be the financial responsibility of the CLTS MCO. The originating and receiving organization are both required to ensure continuity and coordination of services during the transition.~~] Regarding CoLTS MCO and medicaid fee-for-service (FFS) members: If a CoLTS MCO or FFS member is hospitalized at the time of enrollment into or disenrollment from managed care or upon an approved switch from one CoLTS MCO to another, the originating CoLTS 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. 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 CoLTS. Regarding Salud! MCO and CoLTS MCO members: For members transitioning to CoLTS from Salud! or from CoLTS to Salud!, 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 E of 8.307.4.10 NMAC below. 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.

B. **Members receiving hospice services:** Members who have elected and are receiving hospice services prior to enrollment in the [~~coordinated~~] coordination of long-term services program are [~~exempt from enrolling in a CLTS MCO unless they~~] enrolled in a CoLTS MCO and do not have to revoke their hospice election.

C. **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 whether or not obstetrical provider is in CoLTS MCO network. Refer to Paragraph (4) of Subsection H of 8.307.11.9 NMAC for special payment requirements.

D. 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 [~~CLTS MCO~~] CoLTS MCO remains responsible for the member until the member is disenrolled by HSD.

E. **Newborn enrollment:**

A newborn whose mother is a CoLTS MCO member will not be enrolled in CoLTS. The newborn would be enrolled in a managed care program for children/families, in this case, a Salud! MCO. The newborn may have to be temporarily in FFS medicaid until enrollment in managed care is complete.
[8.307.4.10 NMAC - N, 8-1-08; A, 9-1-09]

8.307.4.11 [~~COORDINATED~~] COORDINATION OF LONG-TERM SERVICES STATUS CHANGE: A change of medicaid eligibility for a member enrolled in a [~~CLTS MCO/SE~~] CoLTS MCO/SE may result in disenrollment from the [~~coordinated~~] coordination of long-term services program or change of enrollment status within the [~~CLTS MCO/SE~~] CoLTS MCO/SE.

A. **Effect of exclusion and exempt status on [~~coordinated~~] coordination of long-term services program status:** If the member's medicaid eligibility status changes so that the member is no longer a mandatory [~~CLTS MCO/SE~~] CoLTS MCO/SE participant, the member shall be disenrolled from the [~~CLTS MCO/SE~~] CoLTS MCO/SE. **Enrollment process immediately initiated:** If a member's eligibility status changes requiring mandatory enrollment in the [~~coordinated~~] coordination of long-term services program, the enrollment process shall be initiated.

B. **Change in eligibility without change in [~~coordinated~~] coordination of long-term services status:** If a member's eligibility category changes and enrollment in a [~~CLTS MCO~~] CoLTS MCO is mandatory for the new eligibility category, the member's status as a participant in the [~~coordinated~~] coordination of long-term services program shall not change. Members remain enrolled in the current [~~CLTS MCO~~] CoLTS MCO unless another change occurs that invalidates enrollment with the current [~~CLTS MCO~~] CoLTS MCO.
[8.307.4.11 NMAC - N, 8-1-08; A, 9-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.307.5 NMAC, sections 6, 8 through 13, effective September 1, 2009.

8.307.5.6 OBJECTIVE: The objective of these [~~regulations~~] rules is to provide policies for the service portion of the New Mexico medicaid [~~coordinated~~] coordination of long-term services program.
[8.307.5.6 NMAC - N, 8-1-08; A, 9-1-09]

8.307.5.8 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.
[8.307.5.8 NMAC - N, 8-1-08; A, 9-1-09]

8.307.5.9 ENROLLMENT PROCESS:

A. **Enrollment requirements:** The [~~coordinated~~] coordination of long-term services managed care organization (~~CLTS MCO~~) (CoLTS MCO) shall provide an open enrollment period by region during the implementation in which time it shall accept eligible individuals in the order in which they apply without restriction, unless authorized by the CMS regional administrator, up to any limits contained in the contract. The [~~CLTS MCO~~] CoLTS MCO shall not discriminate on the basis of health status or a need for health care services. The [~~CLTS MCO~~] CoLTS 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. 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 at least 16 calendar days to select a [~~CLTS MCO~~] CoLTS MCO upon notification by the state, or its designee, that eligibility for [~~CLTS~~] CoLTS has been established. If a selection is not made in 16 days, the member shall be assigned to a [~~CLTS MCO~~] CoLTS MCO by the human services department (HSD) or its designee. Members mandated into managed care shall be automatically assigned to the SE.

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

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

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

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

(b) **Newborn enrollment:** A newborn whose mother is a CoLTS MCO member will not be enrolled in CoLTS. The newborn would be enrolled in a managed care program for children/families, in this case, a Salud! MCO. The newborn may have to be temporarily in FFS medicaid until enrollment in managed care is complete.

(3) **Percentage-based assignment (assignment algorithm):** As determined by HSD, members who are not enrolled using the previous methods may be enrolled in a [~~CLTS MCO~~] CoLTS MCO using a percentage-based assignment process. The percentage-based assignments for each [~~CLTS MCO~~] CoLTS MCO may be determined based upon consideration of the [~~CLTS MCO's~~] CoLTS MCO's performance in areas such as quality assurance standards, encounter data submissions, reporting requirements, third party liability collections, marketing plan, community relations, coordination of services, 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 if the member entered a nursing facility while enrolled with the medicaid fee-for-service program and both the member's nursing facility level of care and medicaid eligibility precede the first full month following selection. Retroactive eligibility is limited to a maximum of six months.

E. **Transitioning members, newly eligible members and expedited service requests:** For members newly eligible for medicaid services and not transitioning from an existing home and community-based waiver, PCO, nursing facility or SALUD!, the [~~CLTS MCO~~] CoLTS MCO shall perform an assessment of the member's acute service, long-term service, behavioral health, and social support needs within the first 30 calendar days of enrollment. Authorized covered services shall be initiated within 14 calendar days following the assessment. If it is determined that the member has an emergent need for covered services, the state or its designee shall coordinate with the [~~CLTS MCO~~] CoLTS MCO to have an assessment performed within seven business days and services initiated within seven calendar days following the assessment.

F. **Member lock-in:** Member enrollment in a [~~CLTS MCO~~] CoLTS MCO runs for a 12-month cycle. During the first 90 days after a member initially selects or is assigned to a [~~CLTS MCO~~] CoLTS MCO, the member shall have the option to choose a different [~~CLTS MCO~~] CoLTS MCO to provide services during the member's remaining period of enrollment.

(1) If the member does not choose a different [~~CLTS MCO~~] CoLTS MCO, the member will continue to receive services

from the [~~CLTS MCO~~] CoLTS MCO that provided the member's services during the first 90 days.

(2) If, during the member's first 90 days with a [~~CLTS MCO~~] CoLTS MCO, the member chooses a different [~~CLTS MCO~~] CoLTS MCO, the member will have a 90-day open enrollment period with the new [~~CLTS MCO~~] CoLTS MCO.

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

(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 of the expiration of the lock-in period and the deadline for choosing a new [~~CLTS MCO~~] CoLTS MCO 60 days prior to the expiration date of the member's lock-in period.

(5) If a member loses medicaid eligibility for a period of six months or less, the member will be reenrolled automatically with the member's former [~~CLTS MCO~~] CoLTS MCO, as long as a nursing facility level of care is in place or the member is a full benefit dual eligible. If the member misses the annual disenrollment opportunity during this six-month time period, the member may request to be assigned to another [~~CLTS MCO~~] CoLTS MCO.

(6) Member disenrollment from [~~CLTS~~] CoLTS may occur to enroll in PACE.

G. **Member switch enrollment:** A member who is required to enroll in the [~~coordinated~~] coordination of long-term services program may request to be disenrolled from a [~~CLTS MCO~~] CoLTS MCO and switch to another [~~CLTS MCO~~] CoLTS MCO "for cause" at any time. The member or the member's representative shall make the request in writing to HSD. HSD shall review the request and furnish a written response to the member and the [~~CLTS MCO~~] CoLTS MCO no later than the first day of the second month following the month in which the member or the member's 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 service issues;

(2) family continuity;

(3) an administrative or data entry error in assigning a member to a [~~CLTS MCO~~] CoLTS 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 primary care provider (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 [~~CLTS MCO~~] CoLTS MCO service area;

(6) the [~~CLTS MCO~~] CoLTS 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, but not all related services can be provided by the PCP and another service 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 service, lack of access to services covered under the contract, or lack of access to service providers experienced in dealing with the member's health service needs.

H. **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 or behavioral health services for cause on a case-by-case basis. If the exemption is granted, the member shall receive their behavioral health services through the SE under the medicaid fee-for-service (FFS) program and his/her physical health services under the medicaid FFS program. A member or the member's representative 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 the [~~coordinated~~] coordination of long-term services program at the time of the exemption request, shall remain exempt until a final determination is made. A member already enrolled in the [~~coordinated~~] coordination of long-term services program at the time of the exemption request shall remain in the program 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.

I. **Disenrollment, [~~CLTS MCO/SE~~] CoLTS MCO/SE initiated:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE may request that a particular member be disenrolled from the [~~coordinated~~] coordination of long-term services program. Member disenrollment from a [~~CLTS MCO/SE~~] CoLTS 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 8.307.5.9 NMAC, *enrollment process*. The [~~CLTS MCO/SE~~] CoLTS 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 the member's special needs, except when the member's continued enrollment with the [~~CLTS MCO/SE~~] CoLTS MCO/SE seriously impairs the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's ability to furnish services to either this particular member or other members. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall notify the member in writing of the disenrollment request at the same time the request is submitted to HSD. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall submit a copy of the member's notification letter to HSD. If the disenrollment is granted, the [~~CLTS MCO/SE~~] CoLTS MCO/SE retains responsibility for the member's services until the member is enrolled with another [~~CLTS MCO~~] CoLTS MCO or exempted from the [~~coordinated~~] coordination of long-term services program. In the case of the SE, the member would be exempt from the SE medicaid managed care and would receive behavioral health benefits under the medicaid fee-for-service (FFS) program. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall assist with transition of care.

J. **Conditions under which a [~~CLTS MCO~~] CoLTS MCO may request member disenrollment:** Conditions under which a [~~CLTS MCO/SE~~] CoLTS MCO/SE may request disenrollment are:

(1) the [~~CLTS MCO/SE~~] CoLTS MCO/SE demonstrates that 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE to safely or prudently provide medical or behavioral health services subject to the terms of the contract;

(3) the [~~CLTS MCO/SE~~] CoLTS MCO/SE has offered the member the opportunity in writing to use the grievance procedures; and

(4) the [~~CLTS MCO~~] CoLTS MCO has received threats or attempts of intimidation from the member to the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's service providers or staff.

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

L. **Date of disenrollment:** [~~CLTS MCO/SE~~] CoLTS MCO/SE enrollment, upon approval, shall terminate at the end of a calendar month.

M. **Retroactive enrollment:** A member who is no longer enrolled with a [~~CLTS MCO~~] CoLTS MCO, whether in error or otherwise, shall be retroactively enrolled with the [~~CLTS MCO~~] CoLTS MCO when:

(1) the member continues to meet nursing facility level of care or continues to be a full benefit dual eligible;

(2) the member has been in a nursing facility level of care setting during the period of disenrollment; and

(3) medicaid eligibility has been determined retroactively; retroactive enrollment is limited to six months.

[8.307.5.9 NMAC - N, 8-1-08; A, 9-1-09]

8.307.5.10 ENROLLMENT ROSTERS: The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall receive a monthly roster with the aggregate number of members, member names, member addresses, member social security numbers, member rate cells and member capitation amounts.

[8.307.5.10 NMAC - N, 8-1-08; A. 9-1-09]

8.307.5.11 MEMBER IDENTIFICATION CARD: The [~~CLTS MCO~~] CoLTS MCO shall issue each member a member identification card with its contact information and the SE contact information, within 30 days of enrollment. The card shall be substantially the same as the card issued to commercial members. The card shall not contain information that identifies the member as a medicaid recipient, other than designations commonly used by the [~~CLTS MCOs~~] CoLTS MCOs to identify member benefits, such as group or plan numbers, to service providers.

[8.307.5.11 NMAC - N, 8-1-08; A, 9-1-09]

8.307.5.12 MASS TRANSFER PROCESS: The mass transfer process is initiated when HSD determines that the transfer of members from one [~~CLTS MCO~~] CoLTS 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 [~~CLTS MCO~~] CoLTS MCO identification number or name; and

(2) a significant change in [~~CLTS MCO~~] CoLTS MCO contracting status, including but not limited to, loss of licensure, substandard service, fiscal insolvency or significant loss in network providers.

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

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

D. **Mass transfer based on maintenance:** The mass transfer maintenance function may be triggered when a status change of the [~~CLTS MCO~~] CoLTS MCO is transparent to the member. For instance, a change in the [~~CLTS MCO's~~] CoLTS 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 [~~CLTS MCO~~] CoLTS MCO. Upon initiation of the maintenance function by HSD, members are automatically transferred to the prior [~~CLTS MCO~~] CoLTS MCO experiencing the maintenance change.

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

[8.307.5.12 NMAC - N, 8-1-08; A, 9-1-09]

8.307.5.13 [~~COORDINATED~~] COORDINATION OF LONG-TERM SERVICES AND SINGLE STATEWIDE ENTITY MARKETING GUIDELINES: When marketing to medicaid members, the [~~CLTS MCOs/SE~~] CoLTS MCOs/SE shall follow these marketing guidelines:

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

(1) marketing and outreach materials must meet requirements for all communication with members, as delineated in the quality standards (8.307.8.15 NMAC, *member bill of rights*) and incorporated into the [~~coordinated~~] coordination of long-term services contract;

(2) all marketing and outreach materials produced by the [~~CLTS MCOs/SE~~] CoLTS MCOs/SE under the medicaid [~~coordinated~~] coordination of long-term services and behavioral health contracts 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 five percent in the [~~CLTS MCO/SE~~] CoLTS MCO/SE membership that has limited English proficiency, as identified by the [~~CLTS MCO/SE~~] CoLTS 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, and yellow page advertisement, and web site and presentation materials used by a [~~CLTS MCO/SE~~] CoLTS MCO/SE, [~~CLTS MCO/SE~~] CoLTS MCO/SE representative or [~~CLTS MCO/SE~~] CoLTS MCO/SE subcontractor to attract or retain medicaid enrollment. HSD or its designee may request, review and approve or disapprove any communication to any medicaid member. The [~~CLTS MCOs/SE~~] CoLTS MCOs/SE are not restricted by HSD in their general communications to the public. HSD or its designee 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 [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO's/SE~~] CoLTS MCO's/SE 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 subcontractor 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 a [~~CLTS MCO's/SE~~] CoLTS MCO's/SE strengths:** Misleading information shall not be allowed, even if it is accurate. For example, a [~~CLTS MCO/SE~~] CoLTS MCO/SE may seek to advertise that its health care and home and community-based services 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE. In other words, members might believe that they would have to pay for medicaid health services if they chose another [~~CLTS MCO/SE~~] CoLTS MCO/SE.

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

D. **Marketing and outreach activities not permitted:** The following marketing and outreach activities are not permitted, regardless of the method of communication (oral, written or other) or whether the activity is performed by the [~~CLTS MCO/SE~~] CoLTS MCO/SE directly, its network providers, its subcontractors, or any other party affiliated with the [~~CLTS MCO/SE~~] CoLTS MCO/SE:

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

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

(3) initiating an enrollment request on behalf of a member;

(4) making inaccurate, misleading or exaggerated statements;

(5) asserting or implying that the [~~CLTS MCO~~] CoLTS MCO offers unique covered services where another [~~CLTS MCO~~] CoLTS MCO provides the same or similar services;

(6) the use of more than nominal gifts to entice medicaid members to join a specific health plan;

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

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

(9) explicit direct marketing to members enrolled with other [~~CLTS MCOs~~] CoLTS 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; and

(12) engaging in door-to-door, telephone or other cold call marketing activities, directly or indirectly.

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

F. **Provider communications with medicaid members about [~~CLTS MCO/SE~~] CoLTS MCO/SE options:** HSD marketing restrictions shall apply to [~~CLTS MCO/SE~~] CoLTS MCO/SE subcontractors and service providers, as well as to the [~~CLTS MCO/SE~~] CoLTS MCO/SE. The [~~CLTS MCO/SE~~] CoLTS MCO/SE is required to notify participating service 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE staff prior to enrollment:** Face-to-face meetings requested by members are permitted. These meetings may occur at a mutually agreed upon site. All verbal interaction with members must be in compliance with the guidelines identified in these regulations.

H. **Mailings by the [~~CLTS MCO/SE~~] CoLTS MCO/SE:** [~~CLTS MCO/SE~~] CoLTS 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. The [~~CLTS MCOs/SE~~] CoLTS MCOs/SE may, with HSD approval, provide potential members with information regarding the [~~CLTS MCO/SE~~] CoLTS MCO/SE medicaid benefit package. The [~~CLTS MCOs/SE~~] CoLTS MCOs/SE shall not send gifts, however nominal in value, in these mailings. The [~~CLTS MCOs/SE~~] CoLTS MCOs/SE may send solicited and unsolicited mailings to members and potential members. Unsolicited mailings are defined as: newsletters; notices of outreach events and member services meetings; educational materials; and literature related to preventive medicine initiatives. 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE may hold public meetings. HSD shall be furnished with notice of the meetings and shall prior approve any marketing materials to be presented. HSD, or its designee, shall approve the methodology used by the [~~CLTS MCO/SE~~] CoLTS MCO/SE to solicit attendance for public meetings. HSD or its designee may attend public meetings.

J. **Light refreshments for members at meetings:** The [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE and its service providers, with HSD approval, may disseminate marketing materials, including nominal gifts such as pens, keychains and magnets to potential members.

L. **Gifts to members at health milestones unrelated to enrollment:** Members may be given "rewards" for accessing services. Items that reinforce a member's healthy behavior, or that advertise the member services hotline or the member's PCP office telephone number are examples of "rewards". HSD shall approve gifts with a retail value of over $25.00. Health education videos may be provided.

M. **Marketing time frames:** The [~~CLTS MCOs/SE~~] CoLTS MCOs/SE may initiate marketing and outreach activities at any time.

[8.307.5.13 NMAC - N, 8-1-08; A, 9-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8307.6 NMAC, sections 6 and 8 through 19, effective September 1, 2009.

8.307.6.6 OBJECTIVE: The objective of these [~~regulations~~] rules is to provide policies for the service portion of the New Mexico medicaid [~~coordinated~~] coordination of long-term services program. [8.307.6.6 NMAC - N, 8-1-08; A, 9-1-09]

8.307.6.8 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. [8.307.6.8 NMAC – N, 8-1-08; A, 9-1-09]

8.307.6.9 GENERAL NETWORK REQUIREMENTS: The [~~coordinated~~] coordination of long-term services managed care organization [~~(CLTS MCO)~~] (CoLTS MCO) and the behavioral health statewide entity (SE) shall establish and maintain a comprehensive network of providers willing and capable of serving its members.

A. **Service coverage:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall provide or arrange for the provision of services described in 8.307.7 NMAC, *Benefit Package*, in a timely manner. The [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall contract with the full array of providers necessary to deliver a level of service at least equal to, or better than, community norms. The [~~CLTS MCO~~] CoLTS MCO shall contract with a number of providers sufficient to maintain equivalent or better access than that available under medicaid fee-for-service (FFS). The [~~CLTS MCO~~] CoLTS MCO shall have at least a single case agreement with all current medicaid nursing facility, disabled and elderly (D&E) waiver, and personal care option (PCO) providers as either out-of-network or contracted providers for at least the minimum 60 days during which the prior authorization for these services is being honored. Unless otherwise provided for, the [~~CLTS MCO~~] CoLTS MCO shall pay at least the HSD/MAD fee-for-service rates for services provided to members if the [~~CLTS MCO~~] CoLTS MCO is unable to reach a negotiated rate with a provider. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall take into consideration the characteristics and health/long-term service needs of its individual medicaid populations. The [~~CLTS MCO/SE~~] CoLTS MCO/SE must contractually require that all network providers and subcontractors be in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In establishing and maintaining the network of appropriate providers, the [~~CLTS MCO/SE~~] CoLTS MCO/SE shall consider the following:

(1) the numbers of network providers who are not accepting new medicaid members and have a process for 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall notify the human services department (HSD) or its designee within five working days of unexpected changes to the composition of its provider network that negatively affect members' access or the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's ability to deliver services included in the benefit package in a timely manner. The CoLTS MCO/SE shall regularly update open and closed panel status and post this information on their website. Anticipated material changes in a [~~CLTS MCO/SE~~] CoLTS MCO/SE provider network shall be reported to HSD or its designee in writing within 30 days prior to the change, or as soon as the [~~CLTS MCO/SE~~] CoLTS MCO/SE knows of the anticipated change. A notice of material 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 [~~CLTS MCO/SE's~~] CoLTS MCO's/SE's plan for maintaining access and the quality of member services.

D. **Required policies and procedures:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall maintain policies and procedures on provider recruitment and termination of provider participation with the [~~CLTS MCO/SE~~] CoLTS MCO/SE. Recruitment policies and procedures shall describe how a [~~CLTS MCO/SE~~] CoLTS MCO/SE will respond to a change in its network that affects access and its ability to deliver services in a timely manner. The state shall have the right to review these policies and procedures upon request. The [~~CLTS MCO/SE~~] CoLTS 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 service providers 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;

(8) shall require that each service provider either billing or rendering services to members has a unique identifier in accordance with the provisions of Section 1173(b) of the Social Security Act;

(9) shall ensure that subcontracted direct care agencies initiate and maintain records of criminal history and background investigations for employees providing services;

(10) shall establish mechanisms to ensure that network providers comply with timely access requirements; monitor network providers regularly to determine compliance; and take corrective action with network providers for failure to comply;

(11) shall ensure that network providers are conducting abuse registry screenings in accordance with the Employee Abuse Registry Act and Sections 7.1.12 and 8.11.6 NMAC, *Employee Abuse Registry*;

(12) shall require network providers to report any changes in their capacity to take new medicaid participants or serve current members; and

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

E. **General information submitted to HSD:** The [~~CLTS MCO~~] CoLTS MCO shall maintain an accurate unduplicated list of contracted, subcontracted

and terminated primary care providers (PCPs), specialists, hospitals, and other service providers participating or affiliated with the [~~CLTS MCO~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall submit this list to HSD or its designee on a quarterly basis, and include a clear delineation of all additions and terminations that have occurred since the last submission. [8.307.6.9 NMAC - N, 8-1-08; A, 9-1-09]

8.307.6.10 PROVIDER QUALIFICATIONS AND CREDENTIALING: The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall verify that each contracted or subcontracted service provider (practitioner or facility) participating in or employed by the [~~CLTS MCO/SE~~] CoLTS MCO/SE meets applicable federal and state requirements for licensing, certification, accreditation, credentialing, and recredentialing for the type of care or services within the scope of practice as defined by federal medicaid statutes and state law. The [~~CLTS MCO~~] CoLTS MCO shall have written policies, procedures and standards for service providers that are not required to be licensed, certified or credentialed.

A. **Individual professional service providers:** For individual professional service providers, the [~~CLTS MCO~~] CoLTS MCO shall:

(1) have written policies and procedures for the credentialing process, including the [~~CLTS MCO's~~] CoLTS MCO's initial credentialing of practitioners and service providers and its subsequent recredentialing, recertifying or reappointment of providers;

(2) designate a credentialing committee or other peer review body to make recommendations regarding credentialing decisions;

(3) identify those service providers who fall under the scope of credentialing authority and action; this shall include, at a minimum, all physicians, dentists and other licensed independent practitioners;

(4) comply with all HSD standards for credentialing and recredentialing; and

(5) formally recredential network service providers at least every three years.

B. **Organizational providers:** For organizational providers, the [~~CLTS MCO~~] CoLTS MCO shall:

(1) have written policies and procedures for the initial and ongoing assessment of all organizational providers with which the [~~CLTS MCO~~] CoLTS MCO intends to contract or with which it is contracted; providers include, but are not limited to, hospitals, home health agencies, nursing facilities, personal care service providers, and free-standing surgical centers;

(2) confirm that the service provider is in good standing with state and federal regulatory bodies;

(3) confirm that the service provider has been reviewed and approved by applicable accrediting bodies; and

(4) develop and implement standards of participation that demonstrate that the service provider is in compliance with provider participation requirements under applicable federal law and regulations, if the service provider has not been approved by an accrediting body.

C. **Primary source verification:**

(1) HSD or its designee and the [~~CLTS MCO~~] CoLTS MCO shall mutually agree to a single primary source verification entity to be used by the [~~CLTS MCO~~] CoLTS MCO and its subcontractors in its service provider credentialing process. All [~~CLTS MCOs~~] CoLTS MCOs shall use one standardized credentialing form. The state shall have the right to mandate a standards credentialing application to be used by the [~~CLTS MCO~~] CoLTS MCO and its subcontractors in its service provider credentialing process.

(2) The [~~CLTS MCO~~] CoLTS MCO shall provide HSD or its designee copies of all medicaid service provider specific forms used in its health system operations and credentialing/recredentialing process for prior approval. The forms shall be user-friendly. The [~~CLTS MCO~~] CoLTS MCO shall participate in a workshop to consolidate and standardize forms across all [~~CLTS MCOs~~] CoLTS MCOs and for its credentialing/recredentialing process and applications.

[8.307.6.10 NMAC- N, 8-1-08; A, 9-1-09]

8.307.6.11 UTILIZATION OF OUT-OF-STATE PROVIDERS: To the extent possible, the [~~CLTS MCO/SE~~] CoLTS MCO/SE is encouraged to utilize in-state and border service providers, which are defined as those service providers located within 100 miles of the New Mexico border, Mexico excluded. The [~~CLTS MCO/SE~~] CoLTS MCO/SE may include out-of-state service providers in its network.

[8.307.6.11 NMAC - N, 8-1-08; A, 9-1-09]

8.307.6.12 PRIMARY CARE PROVIDERS: The [~~PCP~~] primary care provider (PCP) must be a participating [~~CLTS MCO~~] CoLTS MCO medical provider that has the responsibility for supervising, coordinating and providing primary health services to members, initiating referrals for specialist services and maintaining the continuity of the member's services. The [~~CLTS MCO~~] CoLTS MCO shall have a formal process for provider education regarding medicaid, the conditions of participation in the network and the provider's responsibilities to the [~~CLTS MCO~~] CoLTS MCO and its members. The training shall also include the identification of special populations and their service needs.

A. **Primary care for dual eligibles:** These PCP regulations apply to all [~~coordinated~~] coordination of long-term services program recipients except members who are dually eligible for medicare and medicaid (dual eligibles), and whose primary and acute physical health services are covered by medicare. For dual eligible members, the [~~CLTS MCO~~] CoLTS MCO is responsible for coordinating the member's primary, acute and long-term care services with the medicare PCP.

B. **Primary care for Native Americans:** The [~~CLTS MCO~~] CoLTS MCO shall develop policies and procedures to ensure that services are coordinated with the Indian Health Service (IHS), tribal 638 programs and facilities, and other tribal entities as appropriate.

C. **Primary care responsibilities:** The [~~CLTS MCO~~] CoLTS 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 services;

(2) coordination and continuity of services with providers who participate within the [~~CLTS MCO's~~] CoLTS MCO's network and with providers outside the [~~CLTS MCO~~] CoLTS MCO network according to [~~CLTS MCO~~] CoLTS 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 not in contract;

(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 [~~CLTS MCO~~] CoLTS MCO to vaccinate members in their offices and not refer members elsewhere for immunizations; [~~the CLTS~~] CoLTS 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 the member's age group;

(7) ensuring that services are coordinated with other types of health and social program providers and that PCPs are identifying and referring members to specialty providers including but not limited to behavioral health, mental health

and substance abuse , children youth and families department (CYFD), and juvenile justice division; as medically necessary;

(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;

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

(10) requiring PCPs to comply with timely access to care requirements, monitor regularly to determine this compliance and take corrective action if there is failure to comply.

D. **Types of PCPs:** The [~~CLTS MCO~~] CoLTS 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 services are more appropriately managed by a specialist, such as members with infectious diseases, chronic illnesses or disabilities;

(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 [~~CLTS MCO~~] CoLTS MCO shall organize its teams to ensure continuity of services 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 service providers who meet the [~~CLTS MCO~~] CoLTS MCO credentialing requirements as a PCP.

E. **Providers that shall not be excluded as PCPs:** The [~~CLTS MCOs~~] CoLTS MCO's shall not exclude providers as PCPs based on the proportion of high-risk patients in their caseloads.

F. **Selection or assignment to a PCP:** The [~~CLTS MCO's~~] CoLTS MCO's 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 a [~~CLTS MCO~~] CoLTS MCO, the [~~CLTS MCO~~] CoLTS MCO shall ensure that each member may choose a PCP within a reasonable distance from the member's residence.

(a) The [~~CLTS MCO~~] CoLTS MCO shall assume responsibility for assisting members with PCP selection.

(b) The process whereby the [~~CLTS MCO~~] CoLTS MCO assigns members to PCPs shall include at least the following features:

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

(ii) the [~~CLTS MCO~~] CoLTS MCO must offer freedom of choice to members in making a selection;

(iii) a member shall choose a PCP within five business days of enrollment with the [~~CLTS MCO~~] CoLTS MCO; a member may select a PCP from the information provided by the [~~CLTS MCO~~] CoLTS MCO; a member may choose a PCP anytime during this selection period;

(iv) the [~~CLTS MCO~~] CoLTS MCO shall make auto-assignments no later than five business days from enrollment for any member who has not selected a PCP in that timeframe; the [~~CLTS MCO~~] CoLTS MCO shall assign a PCP based on factors such as the member's age, residence and, if known, current provider relationship;

(v) the [~~CLTS MCO~~] CoLTS MCO shall notify the member in writing of the name, location and office telephone number of the member's PCP; and

(vi) the [~~CLTS MCO~~] CoLTS MCO shall provide the member with an opportunity to select a different PCP if the member 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 on the first day of the following month. If the request is made after the 20th day of the month, it will become effective no later than 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 parent(s) or legal guardian(s) of a minor or incapacitated adult.

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

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

(b) a member's PCP ceases to participate in the [~~CLTS MCO's~~] CoLTS MCO's network;

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

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

(e) a member's PCP is suspended for potential quality or fraud and abuse issues.

(4) **PCP lock-in:** HSD shall allow the [~~CLTS MCO~~] CoLTS MCO to require that a member see a certain provider while ensuring reasonable access to quality services when utilized services have been identified as unnecessary, when a member's behavior is detrimental, or when a need is indicated to provide case continuity. Prior to placing a member on PCP lock-in, the [~~CLTS MCO~~] CoLTS MCO shall inform the member of the intent to lock-in, including the reasons for imposing the PCP lock-in and notice that the restriction does not apply to emergency services furnished to the member. The [~~CLTS MCO's~~] CoLTS MCO's grievance procedure shall be made available to a member disagreeing with the PCP lock-in. The PCP lock-in shall be reviewed and documented by the [~~CLTS MCO~~] CoLTS MCO and reported to the state every quarter. The member shall be removed from PCP lock-in when the [~~CLTS MCO~~] CoLTS MCO has determined that the utilization problems or detrimental behavior have ceased and that recurrence of the problems is judged to be improbable. The state shall be notified of all lock-in removals at the time they occur.

(5) **Pharmacy lock-in:** HSD shall allow the [~~CLTS MCO~~] CoLTS MCO to require that a member see a certain pharmacy provider for whom compliance or drug seeking behavior is suspected. Prior to placing the member on pharmacy lock-in, the [~~CLTS MCO~~] CoLTS MCO shall inform the member and the member's representative(s) of the intent to lock-in. The pharmacy lock-in shall be reviewed and documented by the [~~CLTS MCO~~] CoLTS MCO and reported to the state every quarter. The member shall be removed from pharmacy lock-in when the [~~CLTS MCO~~] CoLTS MCO has determined that the compliance issue or drug seeking behavior has been resolved and that the

recurrence of the problems is judged to be improbable. The state shall be notified of all lock-in removals at the time they occur.

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

[8.307.6.12 NMAC - N, 8-1-08; A, 9-1-09]

8.307.6.13 LONG-TERM SERVICES PROVIDERS: The [~~CLTS MCO~~] CoLTS MCO shall contract with medical providers, home and community based providers, and institutional providers that have the responsibility for supervising, coordinating and providing long-term services to members.

A. The [~~CLTS MCO~~] CoLTS MCO is prohibited from excluding long-term services providers based on the proportion of high-risk members in their caseloads.

B. The [~~CLTS MCO~~] CoLTS MCO shall have a formal process for provider education regarding the [~~coordinated~~] coordination of long-term services program, the conditions of participation in the program, and the provider's responsibilities to the [~~CLTS MCO~~] CoLTS MCO and its members. The state shall be provided with documentation, upon request, that such provider education is being conducted.

C. The [~~CLTS MCO~~] CoLTS MCO shall retain responsibility for monitoring long-term services provider activities to ensure compliance with the [~~CLTS MCO's~~] CoLTS MCO's policies, and state and federal policies and regulations. The [~~CLTS MCO~~] CoLTS MCO shall educate long-term services providers about special populations and their service needs. The [~~CLTS MCO~~] CoLTS MCO shall ensure that long-term services providers successfully identify and refer members to PCPs for referral to specialty providers as medically necessary.

[8.307.6.13 NMAC - N, 8-1-08; A, 9-1-09]

8.307.6.14 SPECIALTY PROVIDERS:

A. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall contract with a sufficient number of specialists with the applicable range of expertise to ensure that the anticipated needs of its members will be met within the [~~CLTS MCO/SE~~] CoLTS MCO/SE network of service providers. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have a system in place to refer members to service providers who are not affiliated with the [~~CLTS MCO/SE~~] CoLTS MCO/SE network if providers with the necessary qualifications or certifications to provide the required services do not participate in the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's network.

B. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have written policies and procedures for coordination of services and the arrangement and documentation of all referrals. The [~~CLTS MCO/SE~~] CoLTS MCO/SE policies and procedures shall designate the process used by the [~~CLTS MCO/SE~~] CoLTS MCO/SE to ensure that referrals for all medically necessary services are available to members. The [~~CLTS MCO/SE~~] CoLTS MCO/SE referral process shall be effective and efficient and not impede timely access to and receipt of services.

C. A woman in her third trimester of pregnancy at the time of enrollment, who has an established obstetrical provider, may maintain that relationship. (Refer to Paragraph (4) of Subsection H of 8.307.11.9 NMAC, *reimbursement for women in the third trimester of pregnancy*.)

D. The [~~CLTS MCO/SE~~] CoLTS MCO/SE or a specialist may initiate a change of specialists when the member's/guardian's behavior toward the specialist is such that all reasonable efforts have been made to accommodate the member/guardian and address the member's problems, but those efforts have been unsuccessful.

[8.307.6.14 NMAC - N, 8-1-08; A, 9-1-09]

8.307.6.15 ACCESS TO SERVICES: The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall demonstrate that its network is sufficient to meet the health service needs of enrolled members. HSD or its designee shall assess the sufficiency of this network throughout the contract period. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall notify HSD or its designee of changes in its network as required. Changes affecting member access to services shall be communicated to HSD or its designee and remedied by the [~~CLTS MCO/SE~~] CoLTS MCO/SE in an expeditious manner.

A. **Provider to member ratios:**

(1) **PCP to member ratios:** The [~~CLTS MCO~~] CoLTS MCO shall ensure that the member caseload of any PCP in its network does not exceed 1,500 of its own members. Exceptions to this limit may be made with the consent of the [~~CLTS MCO~~] CoLTS MCO and HSD or its designee. Reasons for exceeding the limit may include continuation of established services, assignment of a family unit or availability of mid-level clinicians in the practice that expand the capacity of the PCP.

(2) **Specialist to member ratios:** HSD shall not establish specific specialist to member ratios. The [~~CLTS MCO/SE~~] CoLTS MCO/SE must ensure that its members have adequate access to specialty services.

B. **Compliance with specified access standards:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall comply with all access standards delineated under the terms of the medicaid [~~coordinated~~] coordination of long-term services contract with respect to geographic location and scheduling and wait times.

C. **Requirements for [~~CLTS MCO/SE~~] CoLTS MCO/SE policies and procedures:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall maintain written policies and procedures describing how members and service providers receive instructions on accessing services, including prior authorization and referral requirements for various types of medical or surgical treatments, emergency room services, and behavioral health services. The policies and procedures shall be made available in an accessible format, upon request, to HSD or its designee, network providers and members.

[8.307.6.15 NMAC - N, 8-1-08; A, 9-1-09]

8.307.6.16 OTHER PROVIDERS: The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall demonstrate how it incorporates and utilizes certain other service providers that serve many of the special needs of medicaid members and are considered important in maintaining continuity of services.

A. **Federally qualified health centers (FQHCs) and rural health centers:** The [~~CLTS MCOs/SE~~] CoLTS MCOs/SE shall contract with FQHCs and rural health centers to the extent that access is required by federal law and pursuant to state regulations.

B. **Public health providers:** The [~~CLTS MCOs/SE~~] CoLTS MCOs/SE shall contract with public health service providers, including local and district public health offices, pursuant to state law and regulations.

(1) **Specific requirements for local and district health offices:** The [~~CLTS MCO~~] CoLTS MCO must contract with local and district public health offices to provide the following services:

(a) family planning services;

(b) the [~~CLTS MCO~~] CoLTS MCO may require PCPs to participate in the vaccines for children (VFC) program administered by the department of health; and

(c) the [~~CLTS MCO~~] CoLTS MCO may contract with local and district health offices for other clinical preventive services not otherwise available in the community,

such as prenatal services or perinatal case management.

(2) **Shared responsibility between** [~~CLTS MCO~~] **CoLTS MCO and public health offices:** The [~~CLTS MCO~~] CoLTS MCO shall coordinate with public health offices regarding the following services:

(a) screening, diagnosis, treatment, follow-up and contact investigations of sexually transmitted disease;

(b) HIV prevention counseling, testing and early intervention;

(c) screening, diagnosis and treatment of tuberculosis;

(d) disease outbreak prevention and management, including reporting according to state law requirements, responding to epidemiology requests for information and coordination with epidemiology investigations and studies;

(e) referral and coordination to ensure maximum participation in the supplemental food program for women, infants and children (WIC);

(f) health education services for individuals and families with a particular focus on injury prevention including, but not limited to, car seat use, domestic violence, substance use, and lifestyle issues including tobacco use, exercise and nutrition;

(g) development and support for family support programs, such as home visiting programs for families of newborns and other at-risk families and parenting education;

(h) participating in and support for local health councils to create healthier and safer communities with a focus on coordination of efforts such as DWI councils, maternal and child health councils, tobacco coalitions, safety councils, safe kids and others; and

(i) vaccines for children program.

C. **Children's medical services:** The [~~CLTS MCO~~] CoLTS MCO shall contract with children's medical services, which administers outreach clinics at sites throughout the state. The children's medical service clinics offer pediatric sub-specialty services in local communities, which include cleft palate, neurology, endocrine, asthma and pulmonary services.

D. **School-based providers:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE must make every effort to include school-based health clinics as network providers or provide the same level of access in the school setting.

E. **Assisted living facilities:** The [~~CLTS MCO~~] CoLTS MCO shall ensure that assisted living network providers meet the fundamental principles of practice for home and community-based services, as set forth in the [~~coordinated~~] coordination of long-term services contract.

F. The [~~CLTS MCO~~] CoLTS MCO shall contract with other service providers, as needed, to provide services identified in the member's individualized service plan (ISP).

G. **Indian health services (IHS) and tribal health centers:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall allow members who are Native American to seek services from IHS, tribal or urban Indian program service providers defined in the Indian Health Care Improvement Act (25 U.S.C. Sections 1601 et seq.), whether or not the service provider participates as part of the [~~CLTS MCO's~~] CoLTS MCO's or SE's provider network. The [~~CLTS MCO/SE~~] CoLTS MCO/SE may not prevent members who are IHS beneficiaries from seeking services from IHS, tribal or urban Indian service providers. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall make good faith efforts to contract with service providers that include, but are not limited to, IHS, 638 tribal programs and service providers serving particular linguistic or cultural groups. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall track IHS utilization and expenditures by Native American members. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall not require prior authorization for services provided within the IHS and tribal 638 network. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall accept an individual service provider employed by the IHS or tribal 638 facility who holds a current license to practice in the United States or its territories as meeting licensure requirements.

H. **State-run institutions.** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall make every effort to use certain state-run institutions that provide highly specialized services and provide a "safety net" function for certain high-risk populations.

[8.307.6.16 NMAC - N, 8-1-08; A, 9-1-09]

8.307.6.17 FAMILY PLANNING PROVIDERS: Federal law does not allow restricting access to family planning services for individuals enrolled in medicaid.

A. The [~~CLTS MCO~~] CoLTS MCO shall maintain written policies and procedures defining how members are educated about their right to family planning services, freedom of provider choice and method of accessing such services. The [~~CLTS MCO~~] CoLTS MCO shall ensure that its policies and procedures for accessing family planning services meet specified requirements for member communication.

B. The [~~CLTS MCO~~] CoLTS MCO shall give each member, including adolescents, the opportunity to use the member's PCP, or go to any family planning center, for family planning services without requiring a referral. Each female member shall also have the right to self-refer to a women's health specialist within the [~~CLTS MCO's~~] CoLTS MCO's network for covered services necessary to provide women's routine and preventive health care services. This right to self-refer is in addition to the member's designated source of primary care if that source is not a women's health specialist.

C. Clinics and service providers, including those funded by Title X of the Public Health Service Act, shall be reimbursed by the [~~CLTS MCO~~] CoLTS MCO, regardless of whether they are network or non-network providers. The [~~CLTS MCO~~] CoLTS MCO shall implement procedures to reimburse out-of-network family planning providers that serve its members.

D. Non-participating service providers are responsible for keeping family planning information confidential in favor of the individual patient, even if the patient is a minor.

[8.307.6.17 NMAC - N, 8-1-08; A, 9-1-09]

8.307.6.18 PROVIDER EDUCATION AND COMMUNICATION:

A. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall establish and maintain policies and procedures governing the development and distribution of education and informational materials regarding [~~coordinated~~] coordination of long-term services, including behavioral health, to its network providers. Policies and procedures shall:

(1) inform service providers of the conditions of participation with the [~~CLTS MCO/SE~~] CoLTS MCO/SE;

(2) inform service providers of their responsibilities to the [~~CLTS MCO/SE~~] CoLTS MCO/SE and to medicaid members;

(3) inform service providers of medicaid-specific policies and procedures, including information on primary and specialized medical services and related information and services specific to the needs of individuals with special health care needs (ISHCN) and other special populations;

(4) inform service providers regarding cultural competency and provide ongoing educational opportunities for providers and their staff on cultural competency;

(5) provide information on credentialing and recredentialing, prior authorization and referral processes and how to request and obtain a second opinion;

(6) inform service providers on how to access service coordination services for physical, behavioral and social support needs, including covered benefits and services outside the benefit package;

(7) inform service providers regarding the delivery of federally mandated EPSDT services; and

(8) furnish service providers with information on the [~~CLTS MCO's/SE's~~]

CoLTS MCO's/SE's internal provider grievance process by which providers can dispute a [~~CLTS MCO/SE~~] CoLTS MCO/SE action or file a complaint.

B. In addition to the above, the [~~CLTS MCO/SE~~] CoLTS MCO/SE shall:

(1) conduct an annual service provider satisfaction survey, the results of which will be incorporated into the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's quality improvement (QI) program; survey results will be forwarded to HSD or its designee;

(2) actively solicit input from its network providers in an effort to improve and resolve problem areas related to the [~~coordinated~~] coordination of long-term services program; the information provided will be incorporated into the [~~CLTS MCO's~~] CoLTS MCO's or SE's QI program; and

(3) submit an annual service provider educational training schedule to HSD or its designee that includes the scheduled trainings for its network providers; the [~~CLTS MCO/SE~~] CoLTS MCO/SE shall provide HSD or its designee with evidence, when requested, of ongoing provider educational activities scheduled throughout the year and throughout the state; evidence of such activities may include: a provider education schedule of events held throughout the state; provider manuals distributed to contracted providers and updated at least quarterly; publications, such as brochures and newsletters; media, such as films, videotaped presentations and seminars; and schedules of classroom instruction.

C. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall maintain and continue these activities with its network providers throughout the term of the [~~CLTS MCO/SE~~] CoLTS MCO/SE provider contractual relationship.

[8.307.6.18 NMAC - N, 8-1-08; A, 9-1-09]

8.307.6.19 [~~CLTS MCO/SE~~] CoLTS MCO/SE PROVIDER TRANSITION OF CARE: The [~~CLTS MCO~~] CoLTS MCO/SE shall notify HSD or its designee and the SE shall notify the collaborative of unexpected changes in the composition of its service provider network that would have a significantly negative effect on member access to services or on the [~~CLTS MCO's/SE's~~] CoLTS 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 its contractual obligation, the [~~CLTS MCO~~] CoLTS MCO/SE shall be required to submit a transition plan(s) to HSD or its designee for all affected members [~~and the SE shall be required to submit transition plans to the collaborative for all affected consumers~~].

[8.307.6.19 NMAC - N, 8-1-08; A, 9-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.307.7 NMAC, sections 6, 8 -12, 14 and 16, effective September 1, 2009.

8.307.7.6 OBJECTIVE: The objective of these [~~regulations~~] rules is to provide policies for the service portion of the New Mexico medicaid [~~coordinated~~] coordination of long-term services program.

[8.307.7.6 NMAC - N, 8-1-08; A, 9-1-09]

8.307.7.8 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.

[8.307.7.8 NMAC - N, 8-1-08; A, 9-1-09]

8.307.7.9 BENEFIT PACKAGE: This part defines the medicaid benefit package for which the [~~coordinated~~] coordination of long-term services managed care organization [~~(CLTS MCO)~~] (CoLTS MCO) shall be paid fixed per-member per-month payment rates. The [~~CLTS MCO~~] CoLTS MCO shall cover these services. The [~~CLTS MCO~~] CoLTS MCO shall not delete benefits from the medicaid-defined benefit package. The [~~CLTS MCO~~] CoLTS MCO must utilize service providers licensed in accordance with state and federal requirements to deliver services.

[8.307.7.9 NMAC - N, 8-1-08; A, 9-1-09]

8.307.7.10 MEDICAL ASSISTANCE DIVISION PROGRAM POLICY MANUAL: The medical assistance division program policy manual contains a detailed explanation of the services covered by medicaid, limitations to and exclusions of covered services, and services that are not covered by medicaid. The manual is the official source of information on covered and noncovered services. The [~~CLTS MCO~~] CoLTS MCO shall determine its own utilization management (UM) protocols that are based on reasonable medical evidence and are not bound by those found in the medicaid program manual. The human services department (HSD) or its designee must review and approve the [~~CLTS MCO's~~] CoLTS MCO's UM protocols.

[8.307.7.10 NMAC - N, 8-1-08; A, 9-1-09]

8.307.7.11 SERVICES INCLUDED IN THE [~~COORDINATED~~] COORDINATION OF LONG-TERM SERVICES PROGRAM BENEFIT PACKAGE: The [~~CLTS MCO~~] CoLTS MCO must provide a comprehensive, coordinated and fully integrated system of health care, long-term services, and social and community services to its members. The following are state plan services provided under the authority of the 1915(b) waiver and are available to all [~~CLTS~~] CoLTS members.

A. **Ambulatory surgical services [~~(CLTS MCO)~~] (CoLTS MCO):** The benefit package includes surgical services rendered in an ambulatory surgical center setting, as set forth in 8.324.10 NMAC, *Ambulatory Surgical Center Services*.

B. **Anesthesia services [~~(CLTS MCO)~~] (CoLTS MCO):** The benefit package includes anesthesia and monitoring services necessary for the performance of surgical or diagnostic procedures, as set forth in 8.310.5 NMAC, *Anesthesia Services*.

C. **Audiology services [~~(CLTS MCO)~~] (CoLTS MCO):** The benefit package includes audiology services, as set forth in 8.324.6 NMAC, *Hearing Aids and Related Evaluation*.

D. **Case management services:** The benefit package includes the following case management services:

(1) **case management services for pregnant women and their infants [~~(CLTS MCO only)~~] (CoLTS MCO):** case management services provided to pregnant women up to 60 days following the end of the month of the delivery, as set forth in 8.326.3 NMAC, *Case Managements Services for Pregnant Women and Their Infants*;

(2) **case management services for traumatically brain injured adults [~~(CLTS MCO) only~~] (CoLTS MCO):** case management services provided to adult members (21 years of age or older) who are traumatically brain injured, as set forth in 8.326.6 NMAC, *Case Management Services for Traumatically Brain Injured Adults*;

(3) **case management services for children up to the age of three [~~(CLTS MCO only)~~] (CoLTS MCO):** case management services provided to 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, *Case Management Services for Children Up to Age Three*;

(4) **case management services for the medically at risk [~~(CLTS MCO)~~] (CoLTS MCO):** case management services for individuals who are under 21 and are medically at risk for physical or behavioral health conditions, as set forth in 8.320.5 NMAC, *EPSDT Case Management*; "medically at risk" is defined as those individuals who have a diagnosed physical or behavioral health condition that has a high probability of impairing their cognitive,

emotional, neurological, social, behavioral, or physical development;

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

(6) **case management services for the chronically mentally ill (SE only):** case management services provided to adults who are 18 years of age or older and who are chronically mentally ill, as detailed in 8.326.4 NMAC, *Case Management Services for the Chronically Mentally Ill*.

E. **Dental services** [~~**(CLTS MCO)**~~] **(CoLTS MCO):** The benefit package includes dental services, as set forth in 8.310.7 NMAC, *Dental Services*.

F. **Diagnostic imaging and therapeutic radiology services** [~~**(CLTS MCO)**~~] **(CoLTS MCO):** The benefit package includes medically necessary diagnostic imaging and radiology services, as set forth 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 [~~CLTS MCO~~] CoLTS 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 [~~CLTS MCO~~] CoLTS MCO.

G. **Dialysis services** [~~**(CLTS MCO)**~~] **(CoLTS MCO):** The benefit package includes medically necessary dialysis services, as set forth in 8.325.2 NMAC, *Dialysis Services*. Dialysis providers shall assist members in applying for and pursuing final medicare eligibility determination.

H. **Durable medical equipment and medical supplies** [~~**(CLTS MCO)**~~] **(CoLTS MCO):** The benefit package includes the purchase, delivery, maintenance, and repair of equipment, oxygen, and oxygen administration equipment, nutritional products, disposable diapers, and disposable supplies essential for the use of the equipment, as set forth in 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies.*

I. **Emergency services** [~~**(CLTS MCO)**~~] **(CoLTS MCO):** The benefit package includes emergency and post-stabilization care services. Emergency services are inpatient and outpatient services that are furnished by a qualified service provider and that are needed to evaluate or stabilize an emergency condition. An emergency condition shall meet the definition of emergency, as set forth in 8.307.1.7 NMAC, *definitions*. The [~~CLTS MCO~~] CoLTS MCO shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. Emergency services shall be provided in accordance with Subsection F of 8.307.7.11 NMAC, *diagnostic imaging and therapeutic radiology services*. Post-stabilization care services are covered services related to an emergency condition that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition, such that within reasonable medical probability, no material deterioration of the member's condition is likely to result from or occur during discharge of the member or transfer of the member to another facility.

J. **EPSDT services** [~~**(CLTS MCO)**~~] **(CoLTS MCO):** The benefit package includes the delivery of the federally mandated early and periodic screening, diagnosis and treatment (EPSDT) services set forth in 8.320.2 NMAC, *EPSDT Services*, and the following:

(1) **EPSDT private duty nursing** [~~**(CLTS MCO)**~~] **(CoLTS MCO):** Private duty nursing for the EPSDT population, as set forth in 8.323.4 NMAC, *EPSDT Private Duty Nursing Services*. The services shall be delivered in the member's home or the school setting.

(2) **EPSDT personal care** [~~**(CLTS MCO)**~~] **(CoLTS MCO):** Medically necessary personal care services furnished to members under 21 years of age as part of EPSDT, as set forth in 8.323.2 NMAC, *EPSDT Personal Care Services.*

(3) **Tot-to-teen health checks** [~~**(CLTS MCO)**~~] **(CoLTS MCO):** The [~~CLTS MCO~~] CoLTS MCO shall adhere to the periodicity schedule and ensure that eligible members receive EPSDT screens (tot-to-teen health checks), including:

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

(b) development of a proactive approach to ensure that the services are received by members;

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

(d) development of a systematic communication process with the [~~CLTS MCO's~~] CoLTS MCO's network providers regarding screens and treatment coordination for members;

(e) process to document, measure and ensure compliance with the periodicity schedule; and

(f) development of a proactive process to ensure the appropriate follow-up of evaluations, referrals or treatment, especially early intervention for mental health conditions, vision and hearing screens, and current immunizations.

K. **Health education and preventive services:** The [~~CLTS MCO~~] CoLTS MCO shall:

(1) provide a continuous program of health education without cost to its members; such a program includes publications, media, presentations, and classroom instruction;

(2) provide programs of wellness education;

(3) make preventive service available to members; the [~~CLTS MCO~~] CoLTS MCO shall periodically remind and encourage members to use benefits, including physical examinations, that are available and designed to prevent illness;

(4) initiate targeted prevention initiatives for members with acute and chronic disease; and

(5) develop policies and procedures that encourage the proactive performance of home safety evaluations for all at-risk members transitioning from institutions to community settings.

L. **Home health services** [~~**(CLTS MCO)**~~] **(CoLTS MCO):** The benefit package includes home health services, as set forth in 8.325.9 NMAC, *Home Health Services*.

M. **Hospice services** [~~**(CLTS MCO)**~~] **(CoLTS MCO/SE):** The benefit package includes hospice services, as set forth in 8.325.4 NMAC, *Hospice Care Services.*

N. **Hospital outpatient services** [~~**(CLTS MCO/SE)**~~] **(CoLTS MCO/SE):** The benefit package includes hospital outpatient services for preventive, diagnostic, therapeutic, rehabilitative, or palliative medical or behavioral health services, as set forth in 8.311.2 NMAC, *Outpatient Covered Services*.

O. **Inpatient hospital services** [~~**(CLTS MCO/SE)**~~] **(CoLTS MCO/SE):** The benefit package includes hospital inpatient acute care, procedures and services, as set forth in 8.311.2 NMAC, *Hospital Services*. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall comply with the maternity length of stay as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Coverage for a hospital stay following a normal vaginal delivery may not be limited to less than 48 hours for both the mother and newborn child. Health coverage for a hospital stay in connection

with childbirth following a cesarean section may not be limited to less than 96 hours for both the mother and newborn child.

P. **Laboratory services** [~~**(CLTS MCO/SE)**~~] **(CoLTS MCO/SE):** The benefit package includes all laboratory services provided according to the applicable provisions of the Clinical Laboratory Improvement Act (CLIA), as set forth 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 [~~CLTS MCO~~] CoLTS 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 [~~CLTS MCO~~] CoLTS MCO.

Q. **Nursing facility services** [~~**(CLTS MCO)**~~] **(CoLTS MCO):** The benefit package includes services provided in nursing facilities or hospital swing beds to members expected to reside in those facilities, as set forth in MAD-731, *Nursing Facilities*, and MAD-723, *Swing Bed Hospital Services*.

R. **Nutritional services** [~~**(CLTS MCO)**~~] **(CoLTS MCO):** The benefit package includes nutritional services furnished to pregnant women and children, as set forth in 8.324.9 NMAC, *Nutritional Services*.

S. **Personal care option (PCO) services** [~~**(CLTS MCO)**~~] **(CoLTS MCO):** The benefit package includes PCO services, as set forth in 8.315.4 NMAC, *Personal Care Option Services*.

T. **Pharmacy services** [~~**(CLTS MCO/SE)**~~] **(CoLTS MCO/SE):** The benefit package includes all pharmacy and related services, as set forth in 8.324.4 NMAC, *Pharmacy Services*. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall maintain written policies and procedures governing its drug utilization review (DUR) program in compliance with all applicable federal medicaid laws. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall use a single medicaid preferred drug list (PDL). The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall cover brand name drugs and drug items not generally on the [~~CLTS MCO/SE~~] CoLTS MCO/SE formulary or PDL when determined to be medically necessary by the [~~CLTS MCO/SE~~] CoLTS MCO/SE or through a fair hearing process. The [~~CLTS MCO/SE~~] CoLTS 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 therapeutic ingredient, anti-obesity items, items which are not medically necessary, and cough, cold and allergy medications. The [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO~~] CoLTS MCO shall coordinate as necessary with the SE, and the SE shall coordinate with the [~~CLTS MCO~~] CoLTS 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 CoLTS MCO/SE shall ensure that Native American members accessing the pharmacy benefit at IHS or tribal 638 facilities will be exempt from the CoLTS MCO's/SE's preferred drug list.

(1) The [~~CLTS MCO's~~] CoLTS MCO's preferred drug list (PDL) shall use the following guidelines:

(a) there must be at least one representing drug for each of the categories in the first data bank blue book;

(b) generic substitution shall be based on "AB" rating or clinical need;

(c) for a multiple source, brand name product within a therapeutic class, the [~~CLTS MCO~~] CoLTS MCO may select a representative drug;

(d) the PDL shall follow the centers for medicare and medicaid services (CMS) special guidelines relating to drugs used to treat HIV infection;

(e) the PDL shall include coverage of certain over the counter (OTC) drugs by a licensed practitioner; and

(f) the [~~CLTS MCO~~] CoLTS MCO shall implement an appeals process for service providers who believe that an exception to the PDL should be made for an individual member.

(2) The [~~CLTS MCO~~] CoLTS MCO shall use a PDL developed with consideration of the clinical efficiency, safety and cost effectiveness of drug items, and shall provide medically appropriate drug therapies for members. Drug items not on the PDL must be considered for coverage on a prior authorization basis. Atypical antipsychotic medications must be available in the same manner as conventional antipsychotic medications for the treatment of severe mental illness, including schizophrenia, clinical depression, bipolar disorder, anxiety-panic disorder, and obsessive-compulsive disorder. Upon development, the [~~CLTS MCO~~] CoLTS MCO will be required to deliver its pharmacy benefit package using a single medicaid PDL.

(3) The [~~CLTS MCO~~] CoLTS MCO shall coordinate as necessary with the single statewide entity (SE) when administering pharmacy services, to ensure that member and service provider questions are directed appropriately. The [~~CLTS MCO~~] CoLTS MCO shall edit pharmacy claims to ensure that any authorizations given and claims paid are within the scope of the responsibility of the [~~CLTS MCO~~] CoLTS MCO or the [~~CLTS MCO's~~] CoLTS MCO's pharmacy subcontractor, and shall inform members or providers when the claims fall under the scope of responsibility of the SE. Such determinations will be based primarily on the prescriber and other criteria as provided by the state.

(4) The [~~CLTS MCO~~] CoLTS MCO shall maintain written policies and procedures governing its drug utilization review (DUR) program, in compliance with federal and state law and regulations.

(5) The [~~CLTS MCO~~] CoLTS MCO shall coordinate the delivery of the pharmacy benefit when medicare part D is the primary coverage.

(6) The [~~CLTS MCO~~] CoLTS MCO shall ensure that any member who takes nine or more different prescription medications has their medications reviewed by a medical clinician for appropriateness and the identification and correction of potentially harmful practices, and shall document this review in the member's chart at least every six months.

U. **Physical health services** [~~**(CLTS MCO)**~~] **(CoLTS MCO):** The benefit package includes primary (including those provided in school-based settings) and specialty physical health services provided by a licensed practitioner and performed within their scope of practice, as defined by state law and set forth in 8.310.2.9 NMAC, *medical services providers*; 8.310.9 NMAC, *Midwife Services*, including attending 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: (1) validly contracted with and fully credentialed by the [~~CLTS MCO~~] CoLTS MCO, or (2) validly contracted with the HSD medical assistance division 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, *Federally Qualified Health Center Services*.

V. **Pregnancy termination services** [~~**(CLTS MCO)**~~] **(CoLTS MCO):** The benefit package includes coverage of

pregnancy terminations for rape, incest and endangerment to the life of the mother, as allowed in accordance with 42 CFR Section 441.202. A certification from the network provider must be provided prior to payment. Medically necessary pregnancy terminations that do not meet the requirements of 42 CFR Section 441.202 are excluded from the capitation payment made to the [~~CLTS MCO~~] CoLTS MCO, and shall be reimbursed solely from state funds pursuant to the provisions of 8.325.7 NMAC, *Pregnancy Termination Procedures*.

W. **Preventive health services** [**~~(CLTS MCO)~~**] **(CoLTS MCO):** The benefit package includes preventive health services, including:

(1) **Immunizations:** The [~~CLTS MCO~~] CoLTS MCO shall ensure that, within six months of enrollment, members are current with immunizations according to the type and schedule provided by the most recent version of the recommendations of the advisory committee on immunization practices (ACIP) of the centers for disease control and prevention, public health service, U.S. department of health and human services. This may be done by providing the necessary immunizations or by verifying the immunization history by a method deemed acceptable by the ACIP. "Current" is defined as no more than four months overdue.

(2) **Screens:** The [~~CLTS MCO~~] CoLTS MCO shall ensure that, to the extent possible, asymptomatic members receive and are current for at [~~lest~~] least the following screening services within six months of enrollment or within six months of a change in the standard. The [~~CLTS MCO~~] CoLTS MCO shall require its network providers to perform the appropriate interventions based on the results of the screens. "Current" is defined as no more than four months overdue. The [~~CLTS MCO~~] CoLTS MCO shall ensure that clinically appropriate follow-up or intervention is performed when indicated by the screening results.

(a) **Screening for breast cancer:** Female members age 50-69 who are not at high risk for breast cancer shall be screened annually with mammography and a clinical breast examination. Female members at high risk for developing breast cancer shall be screened as often as clinically indicated.

(b) **Screening for cervical cancer:** Female members with a cervix shall receive papanicolaou (PAP) testing starting at the onset of sexual activity, but at least by 18 years of age, and every three years thereafter until reaching 65 years of age, if prior testing has been consistently normal and the member has been confirmed to be not at high risk. If the member is at high risk, the testing frequency shall be at least annual.

(c) **Screening for colorectal cancer:** Members age 50 and older at normal risk for colorectal cancer shall be screened with annual fecal occult blood testing or sigmoidoscopy at a periodicity determined by the [~~CLTS MCO~~] CoLTS MCO.

(d) **Blood pressure measurement:** Members of all ages shall receive a blood pressure measurement as medically indicated.

(e) **Serum cholesterol measurement:** Male members age 35-65 and female members age 45-65 who are at normal risk for coronary heart disease shall receive serum cholesterol measurement every five years. Those members with multiple risk factors shall also receive HDL-C measurement.

(f) **Screening for obesity:** All members shall receive annual body weight and height measurements to be used in conjunction with a calculation of the body mass index or referenced to a table of recommended weights.

(g) **Screening for elevated lead levels:** Members age nine to 15 months (ideally 12 months old) shall receive a blood lead measurement at least once.

(h) **Screening for diabetes:** Members shall receive a fasting or two-hour post-prandial serum glucose measurement at least once.

(i) **Screening for tuberculosis:** Members shall receive a tuberculin skin test based on the level of individual risk for development of the infection.

(j) **Screening for rubella:** Female members of childbearing ages shall be screened for rubella susceptibility by history of vaccination or by serology at their first clinical encounter in an office setting.

(k) **Screening for visual impairment:** Members three to four years of age shall be screened at least once for amblyopia and strabismus by physical examination and a stereo acuity test.

(l) **Screening for hearing impairment:** Members age 50 and older shall be routinely screened for hearing impairment by questioning them about their hearing.

(m) **Screening for problem drinking and substance abuse:** Adolescent and adult members shall be screened at least once by a careful history of alcohol use or the use of a standardized screening questionnaire, such as the alcohol use disorders identification test (AUDIT) or the four-question CAGE instrument and the substance abuse screening and severity inventory (SASSI). The frequency of screening shall be determined by the results of the first screen and other clinical indications. Members shall be referred to the SE as warranted.

(n) **Prenatal screening:** Pregnant members shall be screened for preeclampsia, D (Rh) incompatibility, down syndrome, neural tube defects, hemoglobinopathies, and vaginal and rectal group B streptococcal infection; and counseled and offered testing for HIV.

(o) **Newborn screening:** At a minimum, newborn members shall be screened for phenylketonuria, congenital hypothyroidism, galactosemia, and any other congenital disease or condition specified in accordance with department of health regulations, specifically 7 NMAC 30.6, *Newborn genetic screening program*.

(p) **Behavioral health screening:** During an encounter with a primary care provider (PCP), a behavioral health screen shall occur.

(3) **Tot-to-teen health checks:** The [~~CLTS MCO~~] CoLTS MCO shall operate a tot-to-teen health check program for members up to 21 years of age to ensure the delivery of federally mandated EPSDT services. Within six months of enrollment, the [~~CLTS MCO~~] CoLTS MCO shall endeavor to ensure that eligible members are current according to the screening schedule for EPSDT services.

(4) **Counseling services:** The [~~CLTS MCO~~] CoLTS MCO shall provide to applicable asymptomatic members counseling on the following unless member refusal is documented: to prevent tobacco use; to promote physical activity; to promote a healthy diet; to prevent osteoporosis and heart disease in menopausal female members; to prevent motor vehicle injuries; to prevent household and recreational injuries; to prevent dental and periodontal disease; to prevent HIV infection and other sexually transmitted diseases; and to prevent unintended pregnancies.

(5) **Health advisor hotline:** The [~~CLTS MCO~~] CoLTS MCO shall provide a toll-free health advisor hotline, which shall provide at least the following:

(a) general health information on topics appropriate to the various medicaid populations, including those with severe and chronic conditions;

(b) clinical assessment and triage to evaluate the acuity and severity of the member's symptoms and make the clinically appropriate referral; and

(c) pre-diagnostic and post-treatment service decision assistance based on symptoms.

(6) **Family planning policy** [**~~(CLTS MCO)~~**] **(CoLTS MCO):** The [~~CLTS MCO~~] CoLTS MCO shall have a written family planning policy to ensure that members of the appropriate age of both sexes who seek family planning services shall be provided with counseling pertaining to the following: methods of contraception; evaluation and treatment of infertility; risk reduction practices for HIV and other sexually transmitted diseases; options for pregnant members who do not wish to keep a child; and options for pregnant members

who may wish to terminate the pregnancy.

(7) **Prenatal care program [~~(CLTS-MCO)~~] (CoLTS MCO):** The [~~CLTS-MCO~~] CoLTS MCO shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal services consistent with the standards of the American college of obstetrics and gynecology. The program shall include at least the following:

(a) educational outreach to all members of childbearing ages;

(b) prompt and easy access to obstetrical services, including providing an office visit with a practitioner within three weeks of having a positive pregnancy test (laboratory or home) unless earlier care is clinically indicated;

(c) risk assessment of all pregnant members to identify high risk cases for special management;

(d) counseling that strongly advises voluntary testing for HIV;

(e) 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;

(f) screening for determination of need of a post-partum home visit; and

(g) coordination with other services in support of good prenatal care, including transportation and other community services and referral to an agency that dispenses free or reduced price baby car seats.

X. **Prosthetics and orthotics [~~(CLTS-MCO)~~] (CoLTS MCO):** The benefit package includes prosthetic and orthotic services, as set forth in 8.324.8 NMAC, *Prosthetics and Orthotics*.

Y. **Rehabilitation services [~~(CLTS-MCO)~~] (CoLTS MCO):** The benefit package includes inpatient and outpatient hospital and outpatient physical, occupational and speech therapy services, as set forth in 8.325.8 NMAC, *Rehabilitation Services*; and licensed speech and language pathology services furnished under the EPSDT program, as set forth in 8.323.5 NMAC, *Licensed Speech and Language Pathologists*.

Z. **Reproductive health services [~~(CLTS-MCO)~~] (CoLTS MCO):** The benefit package includes reproductive health services, as set forth in 8.325.3 NMAC, *Reproductive Health Services*. The [~~CLTS-MCO~~] CoLTS MCO shall provide members with sufficient information to allow them to make informed choices, including: the types of family planning services available; the member's right to access these services in a timely and confidential manner; and the freedom to choose a qualified family planning provider. A female member shall have the right to self-refer to a women's health specialist within the [~~CLTS-MCO's~~] CoLTS MCO's provider network for covered services necessary to provide women's routine and preventive health care services. This right [~~o~~] of self-refer is in addition to the member's designated source of primary care if that source is not a women's health specialist.

AA. **School-based services [~~(CLTS-MCO/SE)~~] (CoLTS MCO/SE):** The benefit package includes services provided in schools, excluding those specified in the individualized education plan (IEP) or individualized family service plan (IFSP), as set forth in 8.320.6 NMAC, *School-Based Services for Recipients Under 21 Years of Age*.

BB. **Service coordination:** The benefit package includes service coordination that is person-centered and intended to support members in pursuing their desired life outcomes by assisting them in accessing support and services necessary to achieve the quality of life that they desire in a safe and healthy environment. Service coordination assists members in gaining access to needed [~~coordinated~~] coordination of long-term services program waiver services; medicaid state plan services; and medical, social, educational and other services, regardless of the funding source for the services to which access is needed.

CC. **Telehealth Services [~~(CLTS-MCO/SE)~~] (CoLTS MCO/SE):** The benefit package includes telehealth services as set forth in 8.310.13 NMMAC, *Telehealth Services.*

DD. **Transplant services [~~(CLTS-MCO)~~] (CoLTS MCO):** 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 set forth in 8.325.5 NMAC, *Transplant Services*. Also see 8.325.6 NMAC, *Experimental or Investigational Procedures, Technologies or Non-Drug Therapies* for guidance on determining if transplants are experimental or investigational.

EE. **Transportation services [~~(CLTS-MCO)~~] (CoLTS MCO):** The benefit package includes transportation services such as ground ambulance, air ambulance, taxicab or handivan, commercial bus, commercial air, meal, and lodging services, as indicated for medically necessary physical and behavioral health services, as set forth in 8.324.7 NMAC *Transportation Services*. In addition, the [~~CLTS-MCO~~] CoLTS MCO must abide by New Mexico law and regulations, specifically NMSA 1978 Section 65-2-97(F), stating that rates paid by the [~~CLTS-MCO~~] CoLTS MCO to transportation providers are not subject to and are exempt from New Mexico public regulation commission approved tariffs. The [~~CLTS-MCO~~] CoLTS MCO is also required to coordinate, manage and be financially responsible for the delivery of the transportation benefit to members receiving physical health services or behavioral health services. The [~~CLS-MCO~~] CoLTS MCO shall coordinate with the SE as necessary to perform this function. Such coordination shall include:

(1) receiving information from and providing information to the SE regarding members and service providers;

(2) meeting with the SE to resolve provider and member issues to improve services, communication and coordination;

(3) contacting the SE, as necessary, to provide quality transportation services; and

(4) maintaining and distributing statistical information and data as may be required.

FF. **Vision services [~~(CLTS-MCO)~~] (CoLTS MCO):** The benefit package includes vision services, as set forth in 8.310.6 NMAC, *Vision Care Services*.

GG. The following are services provided under the 1915 (c) waiver to [~~CLTS~~] CoLTS members who meet specific criteria.

(1) **Adult day health services [~~(CLTS-MCO)~~] (CoLTS MCO):** The benefit package includes adult day health services, which are generally provided for two or more hours per day on a regularly scheduled basis, for one or more days per week, by a licensed adult day-care, community-based facility that offers health and social services to assist eligible members in achieving optimal functioning. Private duty nursing services and skilled maintenance therapies (physical, occupational and speech therapies) may be provided in conjunction with adult day health services by the adult day health service provider or by another service provider. Private duty nursing services and skilled maintenance therapies must be provided in a private setting at the facility.

(2) **Assisted living services [~~(CLTS-MCO)~~] (CoLTS MCO):** The benefit package includes assisted living services, which are residential services that include personal support services, companion services, and assistance with medication administration, as set forth in department of health regulations 7.8.2 NMAC, *Residential Health Facilities*.

(3) **Community transition goods and services, and community relocation specialist services [~~(CLTS-MCO)~~] (CoLTS MCO):** The benefit package includes community transition and relocation specialist services designed to move individuals, where appropriate, from an institutional setting to home and community-based programs, as detailed in

the [~~coordinated~~] coordination of long-term services contract.

(4) **Emergency response services** [**~~(CLTS-MCO)~~**] **(CoLTS MCO):** The benefit package includes emergency response services, including the provision of an electronic device that enables members to secure help in an emergency. The member may also wear a portable "help" button to allow for mobility. The system is connected to the member's telephone and programmed to signal a response center when the "help" button is activated. The response center must be staffed by trained professionals. Emergency response services include installing, testing and maintaining equipment; training members, caregivers and first responders on the use of the equipment; 24-hour monitoring for alarms; checking systems monthly, or more frequently, if warranted by electrical outages, severe weather or other conditions; and reporting member emergencies and changes in the member's condition that may affect service delivery. Emergency categories consist of emergency response, emergency response high need, and emergency response installation/disconnect.

(5) **Environmental modifications** [**~~(CLTS-MCO)~~**] **(CoLTS MCO):** The benefit package includes environmental modifications, including the purchase or installation of equipment or the making of physical adaptations to a member's residence that are necessary to ensure the health, welfare and safety of the member, or to enhance the member's level of independence.

(a) Adaptations include: installing ramps and grab-bars; widening doorways/ hallways; installing specialized electric and plumbing systems to accommodate medical equipment and supplies; installing lifts or elevators; modifying bathroom facilities; adapting turnaround spaces; making specialized accessibility and safety adaptations; making household additions; installing trapeze and mobility tracks for home ceilings; installing automatic door openers and doorbells; installing voice, light or motion-activated electronic devices; making fire safety adaptations; installing air filtering devices; making heating/cooling adaptations; installing glass substitutes for windows and doors; installing modified switches, outlets or environmental controls for home devices; and installing alarm and alert systems or signaling devices.

(b) All environmental modifications shall be provided in accordance with applicable federal and state laws and regulations, and local building codes. The [~~CLTS MCO~~] CoLTS MCO must ensure that proper design criteria is used in planning and designing the adaptation; provide or secure licensed contractor(s) or approved vendor(s) to provide construction/remodeling services; provide administrative and technical oversight of construction projects; provide consultants to family members, waiver providers, and contractors concerning environmental modification projects; and inspect the final environmental modification project to ensure that the adaptations meet the approved plan.

(6) **Private duty nursing services** [**~~(CLTS-MCO)~~**] **(CoLTS MCO):** The benefit package includes private duty nursing services, including activities, procedures and treatment for a physical condition, physical illness or chronic disability. Services include: medication management, administration and teaching; aspiration precautions; feeding tube management; gastrostomy and jejunostomy; skin care; weight management; urinary catheter management; bowel and bladder care; wound care; health education; health screening; infection control; environment management for safety; nutrition management; oxygen management; seizure management and precautions; anxiety reduction; staff supervision; and behavior and self-care assistance.

(7) **Respite services** [**~~(CLTS-MCO)~~**] **(CoLTS MCO):** The benefit package includes respite services provided to members who are unable to care for themselves. Respite services are provided on a short-term basis because of the absence or need for relief of those persons normally providing the services. Respite services may be provided in a member's home or in the community. Services include: assistance with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation, and eating); enhancing self-help skills; providing opportunities for leisure, play and other recreational activities; and allowing community integration.

(8) **Skilled maintenance therapy services** [**~~(CLTS-MCO)~~**] **(CoLTS MCO):** The benefit package includes skilled maintenance therapy services, including occupational, physical and speech language therapy services.

[8.307.7.11 NMAC - N, 8-1-08; A, 9-1-09]

8.307.7.12 BEHAVIORAL HEALTH SERVICES: Behavioral health services provided by the [~~CLTS MCO's~~] CoLTS MCO's network providers will be covered by the [~~CLTS MCO~~] CoLTS MCO, even when the primary diagnosis is a behavioral health diagnosis. Facility costs, including emergency room costs, will be covered by the [~~CLTS MCO~~] CoLTS MCO unless there is a specific psychiatric revenue code on the facility claim form. Any professional services provided by a behavioral health service provider in an emergency room or in an inpatient or outpatient hospital setting will be covered by the SE. Any services provided by a physical health service provider in an emergency room or in an inpatient setting will be covered by the [~~CLTS MCO~~] CoLTS MCO. The SE will cover outpatient hospital services that require the use of a psychiatrist or psychologist revenue code for billing. Pharmacy claims prescribed by a physical health service provider will be covered by the [~~CLTS MCO~~] CoLTS MCO.

[8.307.7.12 NMAC - N, 8-1-08; A, 9-1-09]

8.307.7.14 BEHAVIORAL HEALTH SERVICES INCLUDED IN THE [~~CLTS~~] CoLTS BENEFIT PACKAGE FOR CHILDREN ONLY: The SE shall provide the following medicaid services. The benefit package includes prevention, screening, diagnostic, ameliorative services and other medically necessary behavioral health care and substance abuse treatment or services for medicaid members under 21 years of age whose need for behavioral health services is identified by a licensed health care provider or during an EPSDT screen. All behavioral health care services shall be provided in accordance with the current New Mexico Children's Code and the Children's Mental Health and Developmental Disabilities Act, NMSA Section 32A-6-1 to 32A-6-22. The services include the following:

A. **Inpatient hospitalization in free standing psychiatric hospitals:** The benefit package includes inpatient services in free standing psychiatric hospitals as detailed in 8.321.2 NMAC, *Inpatient Psychiatric Care in Freestanding Psychiatric Hospitals*.

B. **Accredited residential treatment center services:** The benefit package includes accredited residential treatment services as detailed in 8.321.3 NMAC, *Accredited Residential Treatment Center Services*.

C. **Non-accredited residential treatment centers and group homes:** The benefit package includes residential treatment services as detailed in 8.321.4 NMAC, *Non-Accredited Residential Treatment Centers and Group Homes*.

D. **Treatment foster care:** The benefit package includes treatment foster care services as detailed in 8.322.2 NMAC, *Treatment Foster Care*.

E. **Treatment foster care II:** The benefit package includes treatment foster care II, as detailed in 8.322.5 NMAC, *Treatment Foster Care II*.

F. **Outpatient and partial hospitalization services in freestanding psychiatric hospital:** The benefit package includes outpatient and partial hospitalization services provided in freestanding psychiatric hospitals, as detailed in 8.321.5 NMAC, *Outpatient and Partial Hospitalization Services in Freestanding Psychiatric Hospitals*.

G. **Day treatment**

services: The benefit package includes day treatment services, as detailed in 8.322.4 NMAC, *Day Treatment Services*.

H. **Behavior management skills development services (BMSDS):** The benefit package includes behavior management services, as detailed in 8.322.3 NMAC, *Behavior Management Skills Development Services*.

I. **School-based services:** The benefit package includes counseling, evaluation and therapy furnished in a school-based setting, but not when specified in the individual education plan (IEP) or the individualized family service plan (IFSP), as detailed in 8.320.6 NMAC, *School-Based Services for Recipients Under 21 Years of Age*.

J. **Licensed alcohol and drug abuse counselors:** The benefit package includes alcohol and drug abuse counseling, as detailed in [~~MAD 746.6, Licensed Alcohol and Drug Abuse Counselors~~] 8.310.8 NMAC, *Behavioral Health Professional Services*.

K. **Multi-systemic therapy services:** The benefit package includes multi-systemic therapy services, as detailed in 8.322.6 NMAC, *Multi-Systemic Therapy Services.*

[8.307.7.14 NMAC - N, 8-1-08; A, 9-1-09]

8.307.7.16 SERVICES EXCLUDED FROM THE [~~CLTS~~] CoLTS BENEFIT PACKAGE: The following services are not included in the [~~coordinated~~] coordination of long-term services program benefit package:

A. services provided in intermediate care facilities for the mentally retarded (ICF/MR), as set forth in 8.313.2 NMAC, *Intermediate Care Facilities for the Mentally Retarded*;

B. emergency services to undocumented aliens, as set forth in 8.325.10 NMAC, *Emergency Services for Undocumented Aliens*;

C. experimental or investigational procedures, technologies or non-drug therapies, as set forth in 8.325.6 NMAC, *Experimental or Investigational Procedures, Technologies or Non-Drug Therapies*;

D. case management services provided by the children, youth and families department that are defined as child protective services case management, as set forth in 8.320.5 NMAC, *EPSDT Case Management*;

E. case management services provided by the aging and long-term services department, as set forth in 8.326.7 NMAC, *Adult Protective Services Case Management*;

F. case management services provided by the children, youth and families department, as set forth in 8.326.8 NMAC, *Case Management Services for Children Provided by Juvenile Probation and Parole Officers*;

G. services provided in the schools and specified in the IEP or IFSP, as set forth in 8.320.6 NMAC, *School-Based Services for Recipients Under 21 Years of Age*; and

H. services provided under the home and community-based waiver services programs, as set forth in 8.314.2 NMAC, *Disabled and Elderly Home and Community-Based Services Waiver*, the medically fragile waiver, HIV/AIDS waiver, developmentally disabled waiver, and mi via waiver.

[8.307.7.16 NMAC - N, 8-1-08; A, 9-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.307.8 NMAC, sections 6 and 8-19, effective September 1, 2009.

8.307.8.6 OBJECTIVE: The objective of these [~~regulations~~] rules is to provide policies for the service portion of the New Mexico medicaid [~~coordinated~~] coordination of long-term services program.

[8.307.8.6 NMAC - N, 8-1-08, A, 9-1-09]

8.307.8.8 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 lives of their communities.

[8.307.8.8 NMAC - N, 8-1-08; A, 9-1-09]

8.307.8.9 QUALITY MANAGEMENT: [~~The human services department (HSD) recognizes that strong programs of quality improvement (QI) and assurance help ensure that better services are delivered in a cost-effective manner to the member. Under the terms of the medicaid coordinated long-term services contract, quality management (QM) programs are incorporated into health service 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.

[8.307.8.9 NMAC - N, 8-1-08; A, 9-1-09]

8.307.8.10 EXTERNAL QUALITY REVIEW: The state shall retain the services of an external quality review organization (EQRO) in accordance with the Social Security Act Section 1902(a)(30)(C). The [~~coordinated~~] coordination of long-term services managed care organizations [~~(CLTS MCOs)~~] (CoLTS MCOs) shall cooperate fully with the EQRO and demonstrate adherence to HSD's regulations and quality standards. The EQRO shall not be a competitor of the [~~CLTS MCO~~] CoLTS MCO. The [~~CLTS MCO~~] CoLTS MCO shall utilize technical assistance and guidelines offered by the EQRO, when recommended or directed by the state.

[8.307.8.10 NMAC - N, 8-1-08; A, 9-1-09]

8.307.8.11 BROAD STANDARDS:

A. **[~~HEDIS requirement:~~** ~~The CLTS MCO shall submit a copy of its audited health plan employer data and information set (HEDIS) data submission tool to HSD or its designee at the same time it is submitted to NCQA. The CLTS MCO is expected to use and rely upon HEDIS data as an important measure of performance for SD. The CLTS MCO is expected to incorporate the results of each year's HEDIS data submission to its QI/QM plan. The results of the CLTS MCO's HEDIS® Compliance Audit™ shall accompany its data submission tool.~~] **Data requirement:** The CoLTS MCO shall submit a copy of its performance measure/performance improvement data submission tool to HSD or its designee. The CoLTS MCO is expected to use and rely upon HEDIS-like data as an important measure of performance for HSD. The CoLTS MCO is expected to use HEDIS-like data as a measure of performance and to incorporate the results of each year's data submission to its QI/QM plan.

B. **Mental health reporting requirement:** [~~The SE shall be responsible for the collection and submission of a statistically valid New Mexico consumer/family satisfaction project (C/FSP) survey for both 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 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 based on the aggregate survey data results for both the child/family and adult populations.~~] The SE shall collect and submit a statistically valid New Mexico consumer/family satisfaction project (C/FSP) survey for both the medicaid adult and child family population annually. The annual C/FSP survey shall be conducted on a calendar year basis and shall include

non-survey indicators defined by HSD each contract calendar 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.

C. **Collection of clinical data:** [~~For indicators requiring clinical data as a data source, the CLTS MCO shall collect and utilize a sample of clinical records sufficient to produce statistically valid results. The size of the sample shall support stratification of the population by a range of demographic and clinical factors pertinent to the special vulnerable populations served. These populations shall include, but are not limited to, ethnic minorities, homeless, pregnant women, gender and age-based populations.~~] The CoLTS 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 according to parameters requested by the state.

D. **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.

E. **Provision of emergency services:** The [~~CLTS MCO~~] CoLTS 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.

F. **Disease reporting:** The [~~CLTS MCO~~] CoLTS MCO shall require its service providers to comply with disease reporting required by the "New Mexico Regulations Governing the Control of Disease and Conditions of Public Health Significance, 1980".

G. **Other required reporting:** The [~~CLTS MCO~~] CoLTS MCO agrees to comply with all applicable standards, orders and 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 US department of health and human services (HHS) and the appropriate regional office of the environmental protection agency.

[8.307.8.11 NMAC - N, 8-1-08; A, 9-1-09]

8.307.8.12 STANDARDS FOR QUALITY MANAGEMENT AND IMPROVEMENT:

[~~A. **Program structure:** Quality management (QM) is an integrated approach that links knowledge, structure and processes together throughout the CLTS MCO/SE's system to assess and improve quality. The goal of quality improvement (QI) activities is to improve the quality of clinical care and services provided to members in the areas of health service delivery and supportive administrative systems. The CLTS MCO /SE's QM and 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 CLTS MCO/SE shall submit its comprehensive QM/QI plan for the coming year on an annual basis, 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 CLTS MCO/SE shall be reviewed and approved by HSD or its designee annually. The CLTS MCO/SE's QI/QM activities shall demonstrate the linkage of quality improvement projects to findings from multiple quality evaluations, such as the external quality review annual evaluation; opportunities for improvement identified through either the annual HEDIS indicators or state defined performance measures; the annually required consumer satisfaction surveys and service provider surveys; and any findings identified by an accreditation body such as NCQA.~~

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

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

~~(3) The program description shall specify the roles, authority and responsibilities of a designated physician/psychiatrist in the QM/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 CLTS MCO/SE service providers, committee member selection policies, and roles and responsibilities.~~

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

~~(8) The program description shall address QI for all major demographic groups within the CLTS MC or SE.~~

~~(9) The program description shall address member satisfaction and include 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 service providers of results. The CLTS MCOs shall actively solicit through their consumer advisory board or outreach activities the input of members in the development of target protocols and procedures and other feedback regarding the MCO's quality management and improvement system.~~

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

~~(11) The program description/work plan shall address activities aimed at addressing culture-specific health beliefs and behaviors and risk conditions, and shall respond to member and service 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.~~

~~(12) The program description/work plan shall address activities to improve the 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 service providers about the programs and services~~

~~for members assigned to them.~~

~~(13) The program description/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/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/work plan shall include: objectives for the year; activities regarding quality of clinical care and services; timelines; responsible persons; planned monitoring for newly identified and previously identified issues; and an annual evaluation of the QI program.~~

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

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

~~(18) The QM/QI annual written evaluation submitted to HSD shall include a review of completed and continuing QI 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 8.307.8.12 NMAC, *effectiveness of the QI program*).~~

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

A. **Program structure:** The CoLTS MCO/SE's QM and 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. CoLTS MCO/SE's QM/QI activities shall demonstrate the linkage of quality improvement projects to findings from multiple quality evaluations, such as the external quality review (ERQ) annual evaluation; annual HEDIS-like indicators, state defined performance measures and consumer satisfaction surveys and service provider surveys.

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

(2) Internal processes shall be transparent and accountable.

(3) The program description shall address QI for all major demographic groups within the CoLTS MCOor SE.

(4) The QM/QI description/work plan shall address the process by which the CoLTS MCO/SE adopts, reviews, updates and disseminates evidence-based clinical practice guidelines for the provision of services for acute and chronic conditions, including behavioral health (SE only). The CoLTS MCO/SE shall involve its service providers in this process.

(5) The program description/work plan shall address activities to improve the 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 service providers about the programs and services for members assigned to them.

(6) The QM/QI annual written evaluation shall include a review of completed and continuing QI activities that address quality of clinical care and quality of service; determination and documentation of any demonstrated improvements in quality of care and service.

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

(1) [~~recommend QI policy reviews,~~] review and evaluate the results of QI activities, institute needed actions, 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 CLTS MCO/SE's service providers participate actively in the QI activities;~~

~~(4)~~] (3) ensure that the [~~CLTS MCO/SE~~] CoLTS MCO/SE coordinates the 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) ensure that there is a linkage between the QM/QI program and other management activities, such as network changes, benefits redesign, practice feedback to service providers, member health education, and member services, which will be documented in progress reports submitted to HSD or its designee;~~

~~(6) ensure that the results of QI activities, performance improvement projects and reviews are used to improve quality; there will be evidence of communication and use of the results of QI activities, performance improvement projects and reviews, with appropriate individual and institutional service providers;~~

~~(7) ensure that the CLTS MCO/SE coordinated 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 coordinated long-term services, such as compliance with state standards;~~

~~(8) ensure that the CLTS MCO/SE's QM/QI program is applied to the entire range of health services provided through the CLTS MCO/SE by assuring that all major population groups, service 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 five percent of a CLTS MCO/SE's enrollment; and~~

~~(9) ensure that stakeholders/members have an opportunity to provide input.~~]

(4) ensure that the results of QM/QI activities, performance improvement projects and reviews are used to improve quality.

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

D. **Continuous quality improvement/total quality management:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall ensure that both clinical and nonclinical aspects of its quality management program are 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) assurance that the QI process is data driven;

(3) use of member and service provider input to develop CQI activities; and

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

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

[~~(1) The CLTS MCO 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 [CLTS MCO/SE] CoLTS MCO/SE shall add questions about individuals with special health care needs (ISHCN) to all consumer surveys, as appropriate.

[(3)] (2) The [CLTS MCO/SE] CoLTS MCO/SE shall disseminate results of the member satisfaction survey to service providers, providers, the state, and [CLTS MCO/SE] CoLTS MCO/SE members.

[(4)] (3) The [CLTS MCO] CoLTS MCO shall cooperate with the state in conducting a network provider satisfaction survey.

[(5)] (4) The [CLTS MCO/SE] CoLTS MCO/SE shall evaluate member grievances and appeals for trends and specific problems[, including behavioral health problems].

[(6)] (5) The [CLTS MCO/SE] CoLTS MCO/SE shall use input from the consumer advisory board to identify opportunities for improvement [in the quality of CLTS MCO/SE performance.]; and

[(7)] (6) The [CLTS MCO/SE] CoLTS MCO/SE shall implement interventions [to improve its performance] and measure the effectiveness of these interventions.

[(8) The CLTS MCO/SE shall measure the effectiveness of the interventions.

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

F. Health management systems:

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

(a) The [CLTS MCO] CoLTS 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 approving their chronic behavioral health [conditions] patient outcomes.

[(b) The SE shall proactively identify the unduplicated number of adult severally disabled mentally ill (SDMI) and sever 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 CLTS MCO/SE shall report the following adverse events involving SDMI, SED, CSA, and co-occurring mental health and substance abuse member to HSD on a monthly basis: suicides, attempted suicides, involuntary hospitalizations, detentions for protective custody, and detentions for alleged criminal activity utilizing reporting template provided by HSD or its designee. The SE shall utilize HSD's definitions for the identification of these categories of behavioral members for standardization purposes.

(d)] (b) The [CLTS MCO/SE] CoLTS MCO/SE shall proactively identify ISHCN who have or are at increased risk for a chronic physical or behavioral health condition.

[(e)] (c) The [CLTS MCO/SE] CoLTS MCO/SE shall inform and educate its service providers about the use of health management programs for [CLTS MCO/SE] CoLTS MCO/SE members.

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

(g) The CLTS MCO/SE shall periodically update its service providers regarding best practices and on procedures for appropriate health service referrals.]

(d) The CoLTS 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 [CLTS MCO/SE] CoLTS MCO/SE shall pursue continuity of services for members. The [CLTS MCO/SE] CoLTS MCO/SE shall:

[(a) report changes in its provider network to HSD or its designee;

(b) have a defined health service 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) have a defined process to ensure prompt member notification by its service providers of abnormal results of diagnostic laboratory, diagnostic imaging and other testing, and this will be documented in the medical record;

[(d)] (b) 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; and

[(e)] (c) ensure that all medically necessary referrals are arranged and coordinated by either the referring service provider or by the [CLTS MCO/SE's] CoLTS MCO/SE's service coordination unit;

[(f)] (d) implement policies and procedures to ensure that continuity and coordination of services occur across practices[,] and service [provider sites] providers and between [CLTS MCO/SE] CoLTS MCO and SE; in particular, the [CLTS MCO/SE] CoLTS MCO/SE shall coordinate, in accordance with applicable state and federal privacy laws, with other state agencies. [such as the department of health, the children youth and families department protective services and juvenile justice divisions, the corrections department community reentry services, and the schools; in addition, the] The SE shall coordinate services with all applicable state agencies comprising the collaborative; [and]

[(g)] (e) assist and monitor the transitions between service providers for continuity of services in order to avoid abrupt changes in treatment plans and caregivers for members currently being served; and

[(3) At the request of a member or their legal guardian, the CLTS MCO/SE shall provide information to consumer/participants 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.]

(f) shall develop a policy and procedure that addresses the promotion of member compliance with follow up appointments, consultation/referrals and diagnostic laboratory, imaging and other testing.

G. **Clinical practice guidelines:** The [CLTS MCO/SE] CoLTS MCO/SE shall disseminate to service providers 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 [CLTS MCO/SE] CoLTS MCO/SE shall select the clinical issues to be addressed with clinical guidelines based on the needs of the [medicaid] served populations.

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

(3) The [CLTS MCO/SE] CoLTS MCO/SE shall involve board certified service providers [from its network] who are appropriate to the clinical issue in

the development and adoption of clinical practice guidelines.

(4) The [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall distribute the guidelines to the appropriate service providers and to HSD or its designee.

(6) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall annually measure service provider 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) Decision-making in utilization management, member education, interpretation of covered benefits and other areas shall be consistent with those guidelines.

(8) The [~~CLTS MCOs~~] CoLTS MCO's shall implement HSD-approved 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~~] served 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.~~] The [~~CLTS MCO~~] CoLTS MCO shall:

(a) improve the ability to manage chronic illnesses/diseases in order to meet goals based on jointly established targets;

(b) provide comprehensive disease management for a minimum of two [~~(2)~~] chronic diseases using strategies consistent with nationally recognized disease management guidelines;

(c) submit cumulative data-driven measurements from each of its disease management programs to the state according to contract requirements; all disease management data submitted to the state shall be New Mexico medicaid-specific;

(d) submit to the state annually the [~~CLTS MCO~~] CoLTS MCO disease management plan, which includes a program description, overall program goals, measurable objectives, targeted interventions, and its methodology used to identify other diseases for potential disease management programs;

(e) submit to the state annually a quantitative evaluation of the efficacy of the prior year's disease management program; and

(f) demonstrate consistent improvement in the overall disease management program goals annually or maintain mutually agreed upon level of performance with a report to the state.

(9) The [~~CLTS MCOs~~] CoLTS MCOs shall develop targets with protocols and procedures that address the needs of individuals with disabilities, who are not ill, and address quality-of-life enhancing targets needed by people with disabilities.

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

[~~(1)~~] implement performance measures and tracking measures defined by HSD or its designee in collaboration with the [~~CLTS MCO~~] CoLTS MCO; the [~~CLTS MCO~~] CoLTS MCO shall monitor these measures on an ongoing basis and report results to HSD or its designee;

[~~(2)~~] identify and monitor performance measures and tracking measures of home and community-based service delivery, and implement activities designed to improve the coordination of [~~CLTS~~] CoLTS services;

[~~(3)~~] demonstrate consistent and sustainable patterns of improvement from year to year in the overall member satisfaction survey results, disease management initiatives and performance measures;

[~~(4)~~] review outcome data at least quarterly for performance improvement recommendations and interventions; and

[~~(5)~~] provide mechanisms for monitoring, addressing and correcting any evidence of cost-shifting practices by network providers.

(1) Disease management/ performance measures shall be identified at the beginning of each contract year by HSD.

(2) The CoLTS 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 CLTS 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. The CLTS MCO/SE shall:~~

~~(1) implement interventions to improve service provider and system performance as appropriate;~~

~~(2) implement appropriate corrective interventions when it identifies individual occurrences of poor or substandard quality, especially regarding health and safety issues; and~~

~~(3) implement appropriate corrective interventions when it identifies underutilization or over-utilization.~~]

[~~J.~~] I. **Effectiveness of the [~~QI~~] QM/QI program:** The [~~CLTS MCO/SE~~] CoLTS 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.

[~~(1) The CLTS MCO/SE shall perform an annual written evaluation of the QI program and provide a copy to HSD or its designee 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 services, provided to 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.

[8.307.8.12 NMAC - N, 8-1-08; A, 9-1-09]

8.307.8.13 STANDARDS FOR UTILIZATION MANAGEMENT: [~~New Mexico medicaid requires appropriate utilization management (UM) standards to be implemented and activities to be performed so that excellent services are provided in a coordinated fashion with neither over nor under-utilization. The CLTS MCO/SE's UM programs shall be based on standard external national criteria, where available, and established clinical criteria, that are congruent with HSD's medical necessity service definition as defined in 8.307.1.7 NMAC, *definitions*, and are applied consistently in UM decisions by the CLTS MCO/SE. The CLTS MCO/SE's UM program shall assign responsibility to appropriately qualified, educated, trained, and experienced individuals to manage the use of limited resources; maximize the effectiveness of services by evaluating clinical appropriateness; authorize the type and volume of services through fair, consistent and culturally competent decision making; and to assure equitable access to services. These standards shall also apply to pharmacy utilization management including the formulary exception process.~~] The CoLTS MCO/SE's UM programs shall be based on standard external national criteria, where available, and established clinical criteria, that are congruent with HSD's medical necessity service definition. The CoLTS MCO/SE shall request approval from HSD of all UM and level of care criteria not otherwise derived from a nationally recognized resource such as Milliman, Apollo or InterQual. Utilization management (UM) standards shall be applied consistently so quality services are provided in coordinated fashion with neither over- nor under-utilization. The CoLTS MCO/SE's UM program shall assign responsibility to appropriately qualified, educated, trained, and experienced individuals to authorize services through fair, consistent and competent decision making to assure equitable access to services. 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 [~~CLTS MCO~~] CoLTS MCO and entities to which the [~~CLTS MCO/SE~~] CoLTS MCO/SE delegates UM activities.

(2) A designated physician shall have substantial involvement in the design and implementation of the UM program.

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

[~~(4) The CLTS MCO/SE shall ensure that the services are sufficient in amount, duration and scope to be reasonably expected to achieve the purpose for which the services are furnished. The CLTS 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 director or the QI committee.

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

B. **UM decision criteria:** [~~To make utilization decisions, the CLTS MCO/SE~~] The CoLTS 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 CoLTS 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 CoLTS 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, and based on national standards of practice when such standards are available; [~~involve appropriate service providers when developing, adopting and reviewing criteria;~~] and acceptable to the [~~CLTS MCO/SE's~~] CoLTS MCO/SE's medical (or behavioral health) director, peer consultants and relevant local providers. The [~~CLTS MCO/SE~~] CoLTS 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 CLTS MCO/SE~~] The CoLTS 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 CLTS MCO/SE shall maintain evidence that it has reviewed the criteria at specified intervals and that the criteria have been updated, as necessary; and~~] The CoLTS MCO/SE shall maintain evidence that the criteria has been reviewed and updated at specified intervals.

(5) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall state in writing how service providers can obtain UM criteria and shall provide criteria to its service providers upon request.

(6) The CoLTS MCO/SE shall have written policies and procedures describing how health professionals may access the clinical information used to support UM decisions.

C. **Authorization of services:** [~~For the processing of requests for initial and continuing authorization of services, the CLTS MCO/SE~~] The CoLTS 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 to secure additional information.

D. **Use of qualified professionals:** [~~The CLTS MCO/SE shall have written policies and procedures explaining how qualified health professionals shall assess the clinical information used to support UM decisions.~~

~~(1) Appropriately licensed and experienced health care service providers 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 CLTS 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 service provider responsible for justifying the medical necessity.~~] The CoLTS MCO/SE shall 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.

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

(1) **Precertification - routine:**

(a) **Decision:** For precertification of non-urgent (routine) services, the [~~CLTS MCO/SE~~] CoLTS 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) services, the [~~CLTS MCO/SE~~] CoLTS MCO/SE shall notify a service provider of the decision within one working day of making the decision.

(c) **Confirmation - denial:** For denial of non-urgent (routine) services, the [~~CLTS MCO/SE~~] CoLTS MCO/SE shall give the member and service 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 services, the [~~CLTS MCO/SE~~] CoLTS MCO/SE shall make a decision and notify the service provider of the decision within 72 hours of receipt of request. For authorization of urgent services that result in a denial, the [~~CLTS MCO/SE~~] CoLTS MCO/SE shall notify both the member and service provider that an expedited appeal has already occurred.

(b) **Confirmation - denial:** For denial of urgent services, the [~~CLTS MCO/SE~~] CoLTS MCO/SE shall give the member and service provider written or electronic confirmation of the decision within two working days of making the decision. The [~~CLTS MCO/SE~~] CoLTS 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 [~~(5)~~] working days from receipt of request of services.

(4) **Precertification - extensions:** For precertification decisions of non-urgent or urgent services, a 14 calendar day extension may be requested by the member or service provider. A 14 calendar day extension may also be requested by the [~~CLTS MCO/SE~~] CoLTS MCO/SE. The [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall notify a service provider of the decision within one working day of making the decision.

(c) **Confirmation - denial:** For denial of routine continued stay, the [~~CLTS MCO/SE~~] CoLTS MCO/SE shall give the member and service provider written or electronic confirmation within one working day of the decision. The [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall notify a service provider of the decision within one working day of making the decision. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall initiate an expedited appeal for all denials of concurrent urgent services.

(c) **Confirmation - denial:** For denial of urgent continued stay, the [~~CLTS MCO/SE~~] CoLTS MCO/SE shall give the member and service provider written or electronic confirmation within one working day of the decision. The [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE denies a request for services due to the requested service not being covered by medicaid or due to service provider noncompliance with the [~~CLTS MCO/SE's~~] CoLTS MCO/SE's administrative policies, the [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall obtain relevant clinical information and consult with the treating service provider, 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE UM policies and procedures will clearly define in writing for service providers what constitutes relevant clinical information, as well as how to accurately submit authorization requests.

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

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

(1) The [~~CLTS MCO/SE~~] CoLTS

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 [~~CLTS MCO/SE~~] CoLTS 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 CoLTS MCO/SE shall deny that which was determined to be inappropriate, and recommend an appropriate alternative level of care (setting).

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

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

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

~~(4)~~] (6) The [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE, unless the [~~CLTS MCO/SE~~] CoLTS MCO/SE successfully appeals the decision through judicial hearing or arbitration.

H. **Compensation for UM activities:** Each [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS 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) A [~~CLTS MCO/SE~~] CoLTS 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 Investigative Procedures, Technologies or Non-Drug Therapies.*

J. **Evaluation of the UM process:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall evaluate member and service provider satisfaction with the UM process based on member and service provider satisfaction survey results. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall forward the evaluation results to HSD or its designee.

K. **HSD access:** HSD or its designee shall have access to the [~~CLTS MCO/SE's~~] CoLTS MCO/SE's UM review documentation on request.

[8.307.8.13 NMAC - N, 8-1-08; A, 9-1-09]

8.307.8.14 STANDARDS FOR CREDENTIALING AND RECREDENTIALING: The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall document the mechanism for credentialing and recredentialing of service 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 service 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 days from receipt of completed application with all required documentation unless there are extenuating circumstances.~~] The credentialing process shall be completed within 45 days for professional and institutional providers identified in NCQA credentialing requirements. The 45-day turn around time will apply to clean files only and shall not apply to incomplete credentialing applications or applications that reveal a history of sanctions, malpractice issues, or other anomalies requiring further review of information. For providers that do not require credentialing, e.g., environmental modification providers, the [~~CLTS MCO~~] CoLTS MCO will document that these providers are licensed to do business in New Mexico. The CoLTS MCOs shall all use the same primary source verification entity unless there are more cost effective alternatives approved by HSD.

A. **Service provider participation:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have a process for receiving input from participating service providers regarding credentialing and recredentialing of service providers.

B. **Primary source verification:** [~~At the time of credentialing the service provider, the CLTS MCO/SE shall verify the following information from primary sources:~~] The CoLTS 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 service provider 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 service 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 service provider;

(5) board certification if the service provider states on the application that the service provider is board certified in a specialty; [~~and~~]

(6) current, adequate malpractice insurance, according to the [~~CLTS MCO/SE's~~] CoLTS MCO/SE's policy and history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the service provider; and

(7) primary source verification shall not be required for work history.

C. **Credentialing application:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall use the HSD-approved credentialing form. The service 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 service provider is credentialed, the [~~CLTS MCO/SE~~] CoLTS MCO/SE shall receive information on the service provider from the following organizations and shall include the information in the credentialing files:

(1) national practitioner data bank, if applicable to the service provider 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 service provider types, including behavioral health; and

(g) other recognized monitoring organizations appropriate to the service provider's discipline;

(3) [~~sanctions by medicare and medicaid, as applicable.~~] 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, medicaid, the state children's health insurance program or any federal care program.

E. **Evaluation of service provider site and medical records.** [~~At the time of credentialing the CLTS MCO~~] The CoLTS 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 service providers, prior to acceptance and inclusion as participating service providers. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall determine its method for identifying high volume behavioral health service providers.

(1) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall document a structured review to evaluate the site against the [~~CLTS MCO/SE's~~] CoLTS MCO/SE's organizational standards and those specified by the [~~coordinated~~] coordination of long-term services contract.

(2) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall document an evaluation of the medical record keeping practices at each site for conformity with the [~~CLTS MCO/SE's~~] CoLTS MCO/SE's organizational standards.

F. **Recredentialing:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have formalized recredentialing procedures.

(1) [~~The CLTS MCO/SE shall formally recredential its service providers at least every three years. During the recredentialing process the CLTS MCO/SE shall verify the following information from primary sources.~~] The CoLTS MCO/SE shall recredential its service providers at least every three years. The CoLTS 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 service provider as the primary admitting facility;

(c) valid DEA or CSR certificate, if applicable;

(d) board certification, if the service provider 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 service provider; 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 [~~CLTS MCO~~] CoLTS 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 service provider types;[~~and~~]

(i) other recognized monitoring organizations appropriate to the service provider'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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall incorporate data from the following sources in its recredentialing decision-making process for service providers:

(a) member grievances and appeals;

(b) information from quality management and improvement activities; and

(c) medical record reviews conducted under Subsection E of 8.307.8.14 NMAC, *standards for credentialing and recredentialing.*.

G. **Imposition of remedies:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have policies and procedures for altering the conditions of the service provider's participation with the [~~CLTS MCO/SE~~] CoLTS MCO/SE based on issues of quality of care and service. These policies and procedures shall define the range of actions that the [~~CLTS MCO/SE~~] CoLTS MCO/SE may take to improve the service provider's performance prior to termination.

(1) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have procedures for reporting to appropriate authorities, including HSD or its designee, serious quality deficiencies that could result in a service provider's suspension or termination.

(2) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have an appeal process by which the [~~CLTS MCO/SE~~] CoLTS MCO/SE may change the conditions of a service provider's participation based on issues of quality of care and service. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall inform service providers of the appeal process in writing.

H. **Assessment of organizational providers:** The [~~CLTS MCO/SE~~] CoLTS 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. [~~Service providers include, but are not limited to, hospitals, home health agencies, nursing facilities, assisted living 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 CLTS MCO/SE shall confirm that the service 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 CLTS MCO/SE.~~] At least every three years, the CoLTS MCO/SE shall:

(1) [~~The CLTS MCO/SE shall~~] confirm that the service 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 CLTS MCO/SE shall~~] confirm that the service 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.

[8.307.8.14 NMAC - N, 8-1-08; A, 9-1-09]

8.307.8.15 MEMBER BILL OF RIGHTS: [~~Under medicaid coordinated long-term services, members have certain rights and responsibilities and the CLTS MCO/SE~~] The CoLTS MCO/SE shall have policies and procedures governing member rights and responsibilities and require adherence by all providers, including CoLTS 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 service providers in decision making in all aspects of their health services, 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 service decisions.

(7) Members or their legal guardians shall have the right to seek a second opinion from a qualified health care professional within the [~~CLTS MCO/SE~~] CoLTS MCO/SE network, or the [~~CLTS MCO/SE~~] CoLTS 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 service provider is not authorizing requested services.

(8) Members or their legal guardians shall have a right to voice grievances about the services provided by the [~~CLTS MCO/SE~~] CoLTS MCO/SE and to make use of the [~~CLTS MCO/SE's~~] CoLTS 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 service 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 service decisions 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE, its health care services, how to access those services, and the [~~CLTS MCO/SE~~] CoLTS MCO/SE network providers.

(13) Members or their legal guardians shall have the right to be free from harassment by the [~~CLTS MCO/SE~~] CoLTS MCO/SE or its network providers in regard to contractual disputes between the [~~CLTS MCO/SE~~] CoLTS 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) Members or their legal guardians shall have the right to select a [~~CLTS MCO~~] CoLTS MCO and exercise switch enrollment rights without threats or harassment.

B. **Standards for consumer/participant direction**

(1) Members have direct involvement, control, and choice in assessing his/her own needs and identifying, accessing, and managing services and supports to meet those needs. When appropriate, families or representatives shall be involved in the process. In consumer/participant direction, the process shall also include a member's active participation in making key service plan and service priority decisions as well as evaluating the quality of the services rendered.

(2) [~~CLTS MCO~~] CoLTS MCO shall recognize a continuum of different levels of informed decision-making authority, control and autonomy, to the extent desired by the member, at any given point in the course of his/her participation in [~~CLTS~~] CoLTS. These levels shall range from a member choosing not to direct his/her services and instead deferring to trusted family members or representatives of his/her choosing.

(3) Ensure that a member can move across the continuum of decision-making, depending upon his/her needs and circumstances, and shall support the member in his/her decision regarding the level of consumer/participant direction chosen.

C. **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 [~~CLTS MCO/SE~~] CoLTS MCO/SE and service 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 services that they have agreed upon with their service providers or to notify service 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.

D. [~~**CLTS MCO/SE**~~] **CoLTS MCO/SE responsibilities:**

(1) The [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall publish [~~in the member handbook~~] the members' rights and responsibilities from the member bill of rights in the member handbook. [~~CLTS MCO/SE~~] CoLTS MCO/SE shall honor the provisions set forth in the member bill of rights.

(2) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall comply with the grievance resolutions process [~~found~~] delineated in 8.307.12 NMAC, [~~*CLTS MCO/SE Member Grievance System*~~] *Member Grievance Resolution*.

(3) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall provide members or legal guardians with updated information within 30 days of a material change in the [~~CLTS MCO/SE~~] CoLTS 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 members understand the benefits to which they are entitled, and information on grievance, appeal and fair hearing procedures.

(4) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall provide members and legal guardians with access to a toll-free hot line for the [~~CLTS MCO/SE's~~] CoLTS MCO/SE's program for grievance management. The toll-free hot line for grievance management shall include the following features:

(a) does not require a "touch-tone" telephone;

(b) allows communication with members whose primary language is not English or who are hearing impaired; and

(c) is in operation 24 hours per day, seven days per week.

(5) The [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall protect the confidentiality of member information and records.

(a) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall adopt and implement written confidentiality policies and procedures that conform to federal and state laws and regulations.

(b) The [~~CLTS MCO/SE's~~] CoLTS MCO/SE's contracts with service providers shall explicitly state expectations about confidentiality of member information and records.

(c) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall afford members or legal guardians the opportunity to approve or deny release by the [~~CLTS MCO/SE~~] CoLTS MCO/SE of identifiable personal information to a person or agency outside the [~~CLTS MCO/SE~~] CoLTS 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.

(d) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall notify members and legal guardians in a timely manner when information is released in response to a court order.

(e) The [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE delegates member service activity, the [~~CLTS MCO/SE~~] CoLTS MCO/SE shall retain responsibility for documenting [~~CLTS MCO/SE~~] CoLTS MCO/SE oversight of the delegated activity.

(8) Policies regarding consent for treatment shall be disseminated annually to service providers within the [~~CLTS MCO/SE~~] CoLTS MCO/SE network. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have written policies regarding the requirement for service 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have a process to detect, measure and eliminate operational bias or discrimination against members. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall ensure that its service providers and their facilities comply with the Americans with Disabilities Act.

[~~(10) The CLTS 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 [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO~~] CoLTS MCO shall not restrict a member's right to choose a provider of family planning services.

[~~(13)~~] (12) The [~~CLTS MCO/SE's~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE to medicaid members shall be written at a sixth-grade language level and shall be made available in the prevalent population language.

[8.307.8.15 NMAC - N, 8-1-08; A, 9-1-09]

8.307.8.16 STANDARDS FOR PREVENTIVE HEALTH SERVICES: The [~~CLTS MCO~~] CoLTS 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 [~~CLTS MCO~~] CoLTS MCO under these standards shall be adopted[~~,~~] and reviewed at least every two years, updated when appropriate and disseminated to service provider and member. Unless a member refuses and the refusal is documented, the [~~CLTS MCO~~] CoLTS MCO shall provide the following preventive health services or screens or document that the services (with the results) were provided by other means. The [~~CLTS MCO~~] CoLTS 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 services.

A. **Initial assessment:** The [~~CLTS MCO~~] CoLTS MCO shall perform an initial assessment of the medicaid member's health service needs within 90 days of the date the member enrolls in the [~~CLTS MCO~~] CoLTS 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 and sign language, if necessary.

B. **Immunizations:** The [~~CLTS MCO~~] CoLTS 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 CLTS MCO shall provide the immunizations or verify the member's immunization history by a method acceptable to the health advisory committee~~]. The CoLTS MCO shall encourage providers to verify and document all administered immunizations in the New Mexico statewide immunization information system (SIIS).

C. **Screens:** The [~~CLTS MCO~~] CoLTS 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 [~~CLTS MCO~~] CoLTS 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.

(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 (>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 conception, 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 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 [~~CLTS MCO~~] CoLTS 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 [~~CLTS MCO~~] CoLTS 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 [~~CLTS MCO~~] CoLTS 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 [~~CLTS MCO~~] CoLTS MCO shall require PCPs to refer members, whenever clinically appropriate, to behavioral health providers. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall assist the member with an appropriate behavioral health referral.

D. **Counseling:** The [~~CLTS MCO~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO~~] CoLTS 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 [~~CLTS MCO~~] CoLTS 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 [~~CLTS MCO~~] CoLTS 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 services, including an office visit with a service provider within three weeks of having a positive pregnancy test (laboratory or home) unless earlier service 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.

[8.307.8.16 NMAC - N, 8-1-08; A, 9-1-09]

8.307.8.17 STANDARDS FOR MEDICAL RECORDS:

A. **Standards and policies:** The [~~CLTS MCO/SE~~] CoLTS 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 service and quality review.

(1) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have medical record confidentiality policies and procedures in compliance with state and federal guidelines and HIPAA.

(2) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have medical record documentation standards that are enforced with its [~~CLTS MCO/SE~~] CoLTS 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) service 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 or its designee, 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 for members 12 years of age or older;

(l) reports of consultations and referrals;

(m) reports of emergency services, 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:

(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 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 [~~CLTS MCO/SE~~] CoLTS 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 services.

B. **Review of records:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have a process to systematically review service provider medical records to ensure compliance with the medical record standards. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall institute improvement actions when standards are not met.

(1) The EQRO shall conduct reviews of a representative sample of medical records from the [~~CLTS MCO's~~] CoLTS MCO's primary care providers, obstetricians, and gynecologists.

(2) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have a mechanism to assess the effectiveness of organization-wide and practice-site [~~follow-up plans to increase~~] compliance with the [~~CLTS MCO/SE's~~] CoLTS MCO/SE's established medical record standards and goals.

C. **Access to records:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall provide HSD or its designee appropriate access to service provider medical records.

(1) The [~~CLTS MCO~~] CoLTS MCO shall ensure that the PCP maintains a primary

medical record for each member, which contains sufficient medical information from all service providers involved in the member's services, to ensure continuity of services. The [~~CLTS MCO~~] CoLTS MCO shall ensure that service providers involved in the member's services have access to the member's primary medical record, including the SE, when necessary.

(2) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall include provisions in its contracts with service providers for appropriate access to the [~~CLTS MCO/SE's~~] CoLTS 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 service providers, including behavioral health, for each clinical encounter.

(3) [~~The CLTS MCO shall have a policy that ensures the confidential transfer of medical and dental information to another primary medical or dental service provider whenever a primary medical or dental provider leaves the CLTS MCO the member changes primary medical or dental service provider or after a member changes enrollment from one CLTS MCO and enrolls in another CLTS MCO.~~] The CoLTS MCO shall have a policy that ensures the confidential transfer of medical and dental information when a primary medical or dental provider leaves the CoLTS MCO to another CoLTS 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~~] when the member changes behavioral health provider or practitioner. [~~The SE shall have a policy that ensures the confidential transfer of behavioral health information from one collaborative agency to another.~~]

(5) The [~~CLTS MCO/SE~~] CoLTS 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.~~]

[8.307.8.17 NMAC - N, 8-1-08; A, 9-1-09]

8.307.8.18 STANDARDS FOR ACCESS:

A. **Ensure access:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall establish and follow protocols to ensure the accessibility, availability and referral to service providers for each medically necessary service. [~~The CLTS MCO/SE shall submit documentation to HSD or its designee 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 [~~CLTS MCO/SE~~] CoLTS 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 services shall be covered by the [~~CLTS MCO~~] CoLTS 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 [~~CLTS MCO~~] CoLTS 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 overall health of the member. Post-stabilization services 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall ensure that there is no clinically significant delay caused by the [~~CLTS MCO/SE's~~] CoLTS MCO/SE's utilization control measures. Prior authorization is not required for emergency services in or out of the [~~CLTS MCO/SE~~] CoLTS MCO/SE network, and all emergency services shall be reimbursed at the medicaid fee-for-service rate. The [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall ensure that the member has the right to use any hospital or other licensed emergency setting for emergency services, regardless of whether the service provider is contracted with the [~~CLTS MCO/SE~~] CoLTS MCO/SE.

(3) The [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO~~] CoLTS 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 [~~CLTS MCO~~] CoLTS 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 or its designee.

(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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall ensure that a sufficient number of pharmacy providers are available to members. The [~~CLTS MCO/SE~~] CoLTS MCO/SE 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 [~~CLTS MCO~~] CoLTS 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 [~~CLTS MCO~~] CoLTS MCO shall report to HSD or its designee all service provider groups, health centers and individual physician practices and sites in their network that are not accepting new medicaid members.

(2) [~~CLTS MCO~~] CoLTS MCO only: For routine, asymptomatic, member-initiated, outpatient appointments for primary medical services, the request-to-appointment time shall be no more than 30 days, unless the member requests a later time.

(3) [~~CLTS MCO~~] CoLTS MCO only: For routine asymptomatic member-initiated dental appointments, the request to appointment time shall be consistent with community norms for dental appointments.

(4) [~~CLTS MCO~~] CoLTS MCO only: For routine, symptomatic, member-initiated, outpatient appointments for nonurgent primary medical and dental services, the request-to-appointment time shall be no more than 14 days, unless the member requests a later time.

(5) SE only: For non urgent behavioral health care, the request-to-appointment time shall be no more than 14 days, unless the member requests a later time.

(6) [~~CLTS MCO/SE~~] CoLTS MCO/SE: Primary medical, dental and behavioral health service outpatient appointments for urgent conditions shall be available within 24 hours.

(7) [~~CLTS MCO~~] CoLTS 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) [~~CLTS MCO~~] CoLTS 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) [~~CLTS MCO~~] CoLTS 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) [~~CLTS MCO~~] CoLTS 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) [~~CLTS MCO/SE~~] CoLTS MCO/SE: The in-person prescription fill time (ready for pickup) shall be no longer than 40 minutes. A prescription phoned in by a service provider shall be filled within 90 minutes.

(12) [~~CLTS MCO/SE~~] CoLTS MCO/SE: The timing of scheduled follow-up outpatient visits with service providers shall be consistent with the clinical need.

(13) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall ensure that a medically necessary pharmaceutical agent is provided in a clinically timely manner.

(14) The [~~CLTS MCO/SE's~~] CoLTS MCO/SE's preferred drug list (PDL) shall follow HSD guidelines in Subsection O of 8.307.7.11 NMAC, *services included in the salud! benefit package*, *pharmacy services*.

(15) The [~~CLTS MCO~~] CoLTS 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 [~~CLTS MCO~~] CoLTS MCO shall have an emergency response plan for non-customized DME needed on an emergent basis.

(16) The [~~CLTS MCO~~] CoLTS MCO shall approve or deny a request for prescribed medical supplies within seven working days of the request date. The [~~CLTS MCO~~] CoLTS 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 [~~CLTS MCO~~] CoLTS MCO lists of needed supplies monthly; and the [~~CLTS MCO~~] CoLTS 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 [~~CLTS MCO~~] CoLTS MCO shall ensure that members and members' families receive proper instruction on the use of DME and medical supplies provided by the [~~CLTS MCO/SE~~] CoLTS MCO/SE or its subcontractor.

F. **Access to transportation services:** The [~~CLTS MCO~~] CoLTS MCO shall provide the transportation benefit for medically necessary physical and behavioral health. The [~~CLTS MCO~~] CoLTS MCO MCO shall coordinate behavioral health transportation services with the SE[~~, and the SE shall coordinate transportation services with the member's respective CLTS MCO~~]. The [~~CLTS MCO~~] CoLTS MCO shall have sufficient transportation service 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 [~~CLTS MCO~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE is encouraged to use state-of-the-art technology, such as telemedicine, to ensure access and availability of services statewide. [8.307.8.18 NMAC - N, 8-1-08; A, 9-1-09]

8.307.8.19 DELEGATION: Delegation is a process whereby a [~~CLTS MCO/SE~~] CoLTS MCO/SE gives another entity the authority to perform certain functions on its behalf. The [~~CLTS MCO/SE~~] CoLTS MCO/SE is fully accountable for all predelegation and delegation activities and decisions made. The [~~CLTS MCO/SE~~] CoLTS 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~~].

A. A mutually agreed upon document between [~~CLTS MCO/SE~~] CoLTS MCO/SE and the delegated entity shall describe:

(1) the responsibilities of the [~~CLTS MCO/SE~~] CoLTS MCO/SE and the entity to which the activity is delegated;

(2) the delegated activity;

(3) the frequency and method of reporting to the [~~CLTS MCO/SE~~] CoLTS MCO/SE;

(4) the process by which the [~~CLTS MCO/SE~~] CoLTS MCO/SE evaluates the delegated entity's performance; and

(5) the remedies up to, and including, revocation of the delegation, available to the [~~CLTS MCO/SE~~] CoLTS MCO/SE if the delegated entity does not fulfill its obligations.

B. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall document evidence that the [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE's~~] CoLTS MCO/SE's expectations and HSD's standards.

[8.307.8.19 NMAC - N, 8-1-08; A, 9-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.307.9 NMAC, sections 6 and 8 -13, effective September 1, 2009.

8.307.9.6 OBJECTIVE: The objective of these [~~regulations~~] rules is to provide policies for the service portion of the New Mexico medicaid [~~coordinated~~] coordination of long-term services program.

[8.307.9.6 NMAC - N, 8-1-08; A, 9-1-09]

8.307.9.8 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.

[8.307.9.8 NMAC - N, 8-1-08; A, 9-1-09]

8.307.9.9 COORDINATION OF SERVICES:

A. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall develop and implement policies and procedures to ensure access to service coordination for individuals with special health care needs (ISHCN), as set forth in 8.307.15.9 NMAC, *services for individuals with special health care needs*. Service coordination is defined as a service to assist members with special health care needs, on an as needed basis. It is person-centered, family-focused when appropriate, culturally competent, and strengths-based. Service coordination can help to ensure that the physical and behavioral health needs of the medicaid population are identified and that services are provided and coordinated with all service providers, individual members and the family, if appropriate, and authorized by the member. Service coordination operates within the [~~CLTS MCO/SE~~] CoLTS MCO/SE with a dedicated service coordination staff functioning independently, but is structurally linked to the other [~~CLTS MCO/SE~~] CoLTS MCO/SE systems, such as quality assurance, member services and grievances. Service coordination is not "gate keeping" or "utilization management". Clinical decisions shall be based on 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. Services shall be coordinated between both [~~CLTS MCO~~] CoLTS MCO staff and behavioral health staff of the statewide entity (SE). The entity [~~(CLTS MCO or SE)~~] (CoLTS MCO or SE) responsible for the care of the most acute condition shall be the primary lead on service coordination activities, with necessary assistance and collaboration from other entities. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall conduct the following system processes for service 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 service coordination for all medicaid eligible ISHCN, as required by federal regulations.

B. **General service coordination requirements:**

(1) [~~CLTS MCO/SE~~] CoLTS MCO/SE provide statewide service coordination by licensed or otherwise qualified professionals for members with multiple and complex special health care needs. Service coordinators can be licensed registered nurses (RNs), licensed practical nurses (LPNs), licensed social workers, or have a bachelor's degree from an accredited college or university in nursing, social work, counseling, special education, or a closely related field and have a minimum of one year's experience in working with disabled and elderly individuals. This requirement may be waived by the state if the [~~CLTS MCO~~] CoLTS MCO demonstrates that no persons with these qualifications are available in a specified service area. In this circumstance, the [~~CLTS MCO~~] CoLTS MCO may, with state approval, provide a service coordinator with alternative credentials.

(2) [~~CLTS MCO~~] CoLTS MCO only empower members and their family or caregivers to make informed service coordination decisions based on their individualized service plan (ISP) priorities.

(3) [~~CLTS MCO~~] CoLTS MCO only provide support for transition and community reintegration or the least restrictive environment based on the member's ISP goals.

(4) [~~CLTS MCO~~] CoLTS MCO only, ensure that service coordinators are meeting face-to-face or telephonically with those individuals receiving long-term support services as frequently as appropriate to support the member's goals and to foster independence. Face-to-face meetings shall occur at least once quarterly and telephone contacts shall occur at least monthly for the 1915 (c) waiver participants.

(5) [~~CLTS MCO/SE~~] CoLTS MCO/SE develop and implement written policies and procedures approved by the state, which govern how members with multiple or complex special health care needs shall be identified.

(6) [~~CLTS MCO/SE~~] CoLTS MCO/SE develop and implement written policies and procedures governing how service coordination shall be provided for members with special health care needs, as required by federal regulation. The [~~CLTS MCO~~] CoLTS MCO policies shall address the development of the member's ISP, based on a comprehensive assessment of the goals, capacities, and member's condition and the needs and goals of the family. Also included shall be the criteria for evaluating a member's response to services and revising the ISP when indicated. The member or the member's representative shall be involved in the development of the ISP, as appropriate. The member shall have the right to refuse service coordination.

(7) [~~CLTS MCO~~] CoLTS MCO only adhere to clear expectations and requirements related to ISHCN that may include, but are not limited to: direct access to specialists, as needed; relevant

coordinated long-term services specialty providers; relevant emergency resource requirements; relevant rehabilitation therapy services to maintain functionality; relevant clinical practice guidelines for provision of care and services; and relevant utilization management for services.

(8) [~~CLTS MCO~~] CoLTS MCO only develop and implement written policies and procedures that ensure that health and social service delivery is coordinated across service providers, service systems, and varied levels of care to maximize the member's ISP goals and outcomes.

(9) [~~CLTS MCO~~] CoLTS MCO only develop and implement written policies and procedures that ensure that all transitions of service from institutional to community-based services are proactively coordinated with all service providers involved in the member's ISP.

(10) [~~CLTS MCO~~] CoLTS MCO only develop and implement written policies and procedures that ensure that comprehensive service delivery, across varied funding sources, such as medicare and medicaid for dually eligible members, is seamless to the member.

(11) [~~CLTS MCO/SE~~] CoLTS MCO/SE measure and evaluate outcomes and monitor progress of members to ensure that covered services are received, and assist in resolution of identified problems that prevent duplication of covered services.

(12) [~~CLTS MCO~~] CoLTS MCO only specify how service coordination shall be supported by an internal information system.

(13) [~~CLTS MCO~~] CoLTS MCO only develop and implement written policies and procedures to establish a working relationship between service coordinators, network providers, members, and caregivers.

(14) [~~CLTS MCO/SE~~] CoLTS MCO/SE continue to work with school-based providers to identify and coordinate with the child or adolescent's primary care provider (PCP).

C. The service coordinator shall be responsible for the following activities:

(1) [~~CLTS MCO/SE~~] CoLTS MCO/SE communicating to the member the service coordinator's name and how to contact this person;

(2) [~~CLTS MCO/SE~~] CoLTS MCO/SE ensuring and coordinate access to a qualified service provider who is responsible for developing and implementing a comprehensive treatment plan as per applicable provider regulations;

(3) [~~CLTS MCO/SE~~] CoLTS MCO/SE ensuring appropriate coordination between physical and behavioral health services and non-coordinated long-term services; in the case of the SE, also coordinate care among other applicable agencies and the collaborative;

(4) [~~CLTS MCO~~] CoLTS MCO only coordinating the needs and identify the status of co-managed cases with the SE behavioral health service coordinator;

(5) [~~CLTS MCO/SE~~] CoLTS MCO/SE monitoring 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) [~~CLTS MCO~~] CoLTS MCO only ensuring the development of a member's individual plan of service, 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 services and ensures revision of the plan as needed;

(9) [~~CLTS MCO/SE~~] CoLTS MCO/SE involving the member and family in the development of the plan of services, as appropriate; a member or family shall have the right to refuse service coordination or case management, that will be documented in the service coordination file; and

(10) [~~CLTS MCO/SE~~] CoLTS MCO/SE ensuring that all necessary information is shared with key service providers with the member's written permission or documented verbal permission; this information sharing is required to ensure optimum services and communication between primary care and behavioral health care, as well as among involved behavioral health service providers and across other service providing systems.

D. Standards for individual service plan development (ISP):

(1) treatment and service plans may be documented using a form submitted by the [~~CLTS MCO~~] CoLTS MCO approved by the state;

(2) have and comply with written policies and procedures for the development of the ISP, including ensuring that: the member is involved and in control, to the extent possible and desired by the member in development of the ISP; individuals whom the member wishes to participate in the planning process are included in the planning process; the member's needs are assessed and services and goods are identified to meet those needs; the member's desired level of direct management is agreed upon; and responsibilities for implementation of the ISP are identified;

(3) educate each member (or family or legal representatives, as indicated) about the person-centered planning process, the range of covered services; and, depending on the member's desired level of self-management, any additional information to assist the member during development of the ISP; and

(4) upon completion of a comprehensive assessment, according to parameters identified in the [~~CLTS MCO~~] CoLTS MCO contract, the [~~CLTS MCO~~] CoLTS MCO shall:

(a) begin the ISP development process; the member shall be the center of the planning process, in collaboration with the [~~CLTS MCO~~] CoLTS MCO service coordinator and other individuals of the member's planning team; the planning team shall be composed according to criteria identified in the [~~CLTS MCO~~] CoLTS MCO contract;

(b) convene the planning team to develop and implement the ISP in accordance with contract requirements; the [~~CLTS MCO~~] CoLTS MCO service coordinator will inform and educate the member (or his/her family, legal guardian, or representative, as indicated) about waiver services and other resources available to meet the member's needs;

(c) ensure that the member (or his/her family, legal guardian, or representative, as indicated), in collaboration with his/her planning team, identifies preferred outcomes for services, goals, and the supports necessary to reach the member's desired goals and outcomes; risks associated with the outcomes, and methods to mitigate those risks shall be identified, while acknowledging and promoting the member's independence;

(d) list specific interventions in the ISP for implementing each goal including measurable objectives, services, supports, timelines, and assignments for individuals who are responsible for implementation, and methods of measuring and evaluating outcomes of the ISP; the ISP shall address all services provided to the member, including through [~~CLTS~~] CoLTS, medicare, community resources, natural supports, and other resources; and

(e) review and update the ISP annually, or more frequently, if needed, or when the member or caregiver requests; the member is at risk of significant harm; the member experiences a significant medical

event or change in condition/functioning, e.g., hospitalization, frequent falls, serious accident or illness; the member experiences a significant change in social supports or environment, e.g., caretaker becomes ill, home is damaged; or the member has been referred to adult protective services because of abuse, neglect, or exploitation.

E. For clarification purposes, activities provided through service coordination at the [~~CLTS MCO/SE~~] CoLTS 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.

[8.307.9.9 NMAC - N, 8-1-08; A, 9-1-09]

8.307.9.10 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 [~~CLTS MCO~~] CoLTS MCO and SE. The [~~CLTS MCO~~] CoLTS MCO and SE shall coordinate a member's services with one another, if the member has both physical and behavioral health needs. Both physical and behavioral service 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 [~~CLTS MCO~~] CoLTS MCO and the SE shall develop and share policies and procedures to ensure effective service coordination across systems as authorized by the member. The [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall implement policies and procedures that maximize service 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 [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO~~] CoLTS 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 referral for physical health consultation and treatment when accessing needed physical health services. The SE shall coordinate care with primary care providers, with the written consent.

E. **Referral policies and procedures:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall offer statewide trainings to all service providers regarding its specific referral policies and procedures. The [~~CLTS MCO/SE~~] CoLTS MCO/SE referral policies and procedures shall also be provided in provider manuals distributed to all contracted service providers. The [~~CLTS MCO/SE~~] CoLTS 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. 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 seven calendar days after screen and evaluation. The [~~CLTS MCO~~] CoLTS MCO shall ensure that its policies and procedures for service coordination ensure that referrals to other specialists, non-network providers, and all publicly supported providers for medically necessary and home and community-based covered services are available to members, if such services are not reasonably available in the [~~CLTS MCO~~] CoLTS MCO network. The [~~CLTS MCO~~] CoLTS MCO policy for non-network providers shall require the [~~CLTS MCO~~] CoLTS MCO to coordinate with the non-network provider with regard to payment unless otherwise agreed to by the [~~CLTS MCO~~] CoLTS MCO and HSD or its designee.

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 [~~CLTS MCO~~] CoLTS MCO shall educate and assist physical health providers to make appropriate referrals for 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

[~~CLTS MCO~~] CoLTS MCO as authorized by the member.

H. **Independent access:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall develop and implement policies and procedures that allow member's 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 service 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 service for the member. Community case managers shall be responsible for monitoring the treatment plan and coordinating treatment team meetings for members receiving behavioral health services from multiple service providers.

J. **On-going reporting:**

(1) The [~~CLTS MCO~~] CoLTS 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.

(2) 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

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.

[8.307.9.10 NMAC - N, 8-1-08; A, 9-1-09]

8.307.9.11 COORDINATION WITH WAIVER PROGRAMS: The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have policies and procedures governing coordination of services with home and community-based medicaid waiver programs to assist with complex service coordination. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall coordinate services with the member's [~~waiver case manager~~] 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 or its designee shall monitor utilization of services by waiver recipients to ensure that the [~~CLTS MCO/SE~~] CoLTS MCO/SE provides to members who are waiver participants all benefits included in the medicaid benefit package.

[8.307.9.11 NMAC - N, 8-1-08; A, 9-1-09]

8.307.9.12 COORDINATION OF SERVICES WITH CHILDREN, YOUTH AND FAMILIES DEPARTMENT (CYFD) AND AGING AND LONG TERM SERVICES DEPARTMENT (ALTSD): The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have policies and procedures governing coordination of services with the CYFD protective services division (PSD) and juvenile justice division (JJD). If the member is receiving case management services through CYFD, the primary responsibility for the case management function remains with CYFD, and the [~~CLTS MCO/SE~~] CoLTS MCO/SE shall assist with service coordination. If child protective services (CPS) or juvenile justice division (JJD) has an open case on a member, the CYFD social worker assigned to the case shall be involved in the assessment and treatment plan, including decisions regarding the provision of services for the member. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have policies and procedures governing coordination of services with ALTSD's adult protective services. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall ensure that any APS worker actively involved in an individual's life is included in service coordination. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall assist CYFD and ALTSD staff in identifying access to all medically necessary services identified in the service coordination plan. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall designate a single contact point within the [~~CLTS MCO/SE~~] CoLTS MCO/SE for service coordination purposes.

A. **Children's code compliance:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE policies and procedures shall comply with the current New Mexico Children's Code.

B. **Adult Protective Services Act compliance:** The [~~CLTS MCO/SE's~~] CoLTS MCO/SE's policies and procedures shall comply with New Mexico Statutes, Chapter 27, Section 7 (27-7-14 through 27-7-31), the "Adult Protective Services Act."

[8.307.9.12 NMAC - N, 8-1-08; A, 9-1-09]

8.307.9.13 COORDINATION OF SERVICES WITH SCHOOLS: The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall implement policies and procedures regarding coordination with the public schools for members receiving medicaid services excluded from [~~coordinated~~] coordination of long-term services, as specified by an individual education plan (IEP) or individualized family service plan (IFSP). If the member receives case management through the IEP or IFSP, the primary responsibility for the case management function remains with the school, and the [~~CLTS MCO/SE~~] CoLTS MCO/SE shall assist with service coordination. Coordination between the schools and the [~~CLTS MCO/SE~~] CoLTS MCO/SE shall ensure that members receive medically necessary services that complement the IEP or IFSP services and promote the highest level of function for the child. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall be responsible for implementing policies and procedures for coordination of services for children returning to school after extended absences, which may be due to inpatient, residential treatment services or treatment foster care placement.

[8.307.9.13 NMAC - N, 8-1-08; A, 9-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.307.10 NMAC, sections 6, 8, 9, 11 and 12, effective September 1, 2009.

8.307.10.6 OBJECTIVE: The objective of these [~~regulations~~] rules is to provide policies for the service portion of the New Mexico medicaid [~~coordinated~~] coordination of long-term services program.

[8.307.10.6 NMAC - N, 8-1-08; A, 9-1-09]

8.307.10.8 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.

[8.307.10.8 NMAC - N, 8-1-08; A, 9-1-09]

8.307.10.9 ENCOUNTERS: The [~~coordinated~~] coordination of long-term services managed care organization [~~(CLTS MCO)~~] (CoLTS MCO) and single statewide entity (SE) shall submit encounter

data to the human services department (HSD) under requirements established by HSD or its designee. The centers for medicare and medicaid services (CMS) require that encounter data be used for rate-setting purposes and for reporting cost neutrality for services rendered under the section 1915(c) waiver. HSD maintains oversight responsibility for evaluating and monitoring the volume, timeliness and quality of encounter data submitted by the [~~CLTS MCO/SE~~] CoLTS MCO/SE. If a [~~CLTS MCO/SE~~] CoLTS MCO/SE contracts with a third party to process and submit encounter data, the [~~CLTS MCO/SE~~] CoLTS MCO/SE remains responsible for the quality, accuracy and timeliness of the encounter data submitted to HSD. HSD or its designee shall communicate directly with the [~~CLTS MCO/SE~~] CoLTS MCO/SE, not with the third party contractor, regarding requirements, deficiencies, quality, accuracy and timeliness of encounter data. [~~CLTS MCO/SE~~] CoLTS MCO/SE encounter data shall be used to determine compliance with performance measures and other contractual requirements, as appropriate.
[8.307.10.9 NMAC - N, 8-1-08; A, 9-1-09]

8.307.10.11 ENCOUNTER SUBMISSION TIMEFRAMES: The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall submit encounter data to HSD within 120 days of the service delivery date or discharge. HSD or its designee shall establish error thresholds, time frames and procedures for the submission, correction and resubmission of encounter data.
[8.307.10.11 NMAC - N, 8-1-08; A, 9-1-09]

8.307.10.12 ENCOUNTER DATA ELEMENTS: Encounter data elements are a combination of those elements required by Health Insurance Portability and Accountability Act of 1996 (HIPAA) -compliant transaction formats, which comprise a minimum core data set for states and the [~~CLTS MCO/SE~~] CoLTS MCO/SE, and those required by CMS, HSD [~~or the collaborative~~] for use in the [~~coordinated~~] coordination of long-term services program. Encounter data elements are specified in the [~~medicaid~~] MCO/CSP systems manual. HSD or its designee may increase or reduce or make mandatory or optional, data elements as it deems necessary.
[8.307.10.12 NMAC - N, 8-1-08; A, 9-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.307.11 NMAC, Sections 6, 8 and 9, effective September 1, 2009.

8.307.11.6 OBJECTIVE: The objective of these [~~regulations~~] rules is to provide policies for the service portion of the New Mexico medicaid [~~coordinated~~] coordination of long-term services program.
[8.307.11.6 NMAC - N, 8-1-08; A, 9-1-09]

8.307.11.8 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.
[8.307.11.8 NMAC- N, 8-1-08; A, 9-1-09]

8.307.11.9 REIMBURSEMENT FOR [~~COORDINATED~~] COORDINATION OF LONG-TERM SERVICES:

A. **Payment for services:** The human services department (HSD) shall make actuarially sound payments under capitated risk contracts to the designated [~~coordinated~~] coordination of long-term services managed care organizations [~~(CLTS MCOs)~~] (CoLTS MCOs) and single statewide entity (SE). Rates, whether set by HSD or negotiated between HSD and the [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall be responsible for the provision of services to members during the month of capitation. Medicaid members shall not be liable for debts incurred by a [~~CLTS MCO/SE~~] CoLTS MCO/SE under the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's contract for providing health services to medicaid members. This shall include, but not be limited to:

(1) the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's debts in the event of its insolvency;

(2) services provided to the member that are not included in the medicaid benefit package and for which HSD does not pay the [~~CLTS MCO/SE~~] CoLTS MCO/SE, e.g. value added services;

(3) when the [~~CLTS MCO/SE~~] CoLTS MCO/SE does not pay the service 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE provided the service directly; and

(5) if a [~~CLTS MCO/SE~~] CoLTS MCO/SE member loses eligibility for any reason and is reinstated as eligible by HSD before the end of the month, the [~~CLTS MCO/SE~~] CoLTS MCO/SE shall accept a retro capitation payment for that month of eligibility and assume financial responsibility for all medically necessary covered benefits and services supplied during that month to the member.

B. **Capitation disbursement requirements:** HSD shall pay a capitated amount to the [~~CLTS MCO/SE~~] CoLTS MCO/SE for the provision of the [~~coordinated~~] coordination of long-term services benefit package at specified rates. The monthly rate is based on actuarially sound capitation rate cells. The [~~CLTS MCO/SE~~] CoLTS 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 or its designee will calculate or verify the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's income at the end of the state fiscal year to determine if expenditures were made 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE-delegated entities (if applicable), and other financial information will be monitored. The [~~CLTS MCO/SE~~] CoLTS MCO/SE does not have the option of deleting benefits from the medicaid defined benefit package. Should the [~~CLTS MCO/SE~~] CoLTS 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 timeframes:** Clean claims as defined in Subsection L of 8.307.1.7 NMAC, *definitions*, shall be paid by the [~~CLTS MCO/SE~~] CoLTS MCO/SE to contracted and noncontracted service 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 42 CFR Section 447.45. For claims from day activity providers, assisted living providers and home health agencies including PCO and D&E providers, such turnaround times shall be 95 percent of claims within 14 calendar days and 99 percent of claims in 21 calendar days, provided such claims meet the definition of clean claims, are submitted electronically and meet all HIPAA transaction standards. The date of receipt is the date that the [~~CLTS MCO/SE~~] CoLTS MCO/SE first receives the claim, either manually or electronically. The [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/

SE and its service 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall be financially responsible for paying all claims for all covered emergency and post-stabilization services that are furnished by noncontracted service providers, at no more than the medicaid fee-for-service (FFS) rate, including medically or clinically necessary testing to determine if a physical or behavioral health emergency exists.

(1) A [~~CLTS MCO/SE~~] CoLTS MCO/SE shall pay contracted and noncontracted service providers interest on the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's liability at the rate of 1.5 percent per month on the amount of a clean claim (based upon the current medicaid fee schedule) submitted by the participating service 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall be required to report the number of claims and the amount of interest paid, on a timeframe determined by HSD or its designee.

(2) No contract between the [~~CLTS MCO/SE~~] CoLTS MCO/SE and a participating service provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions.

(3) If the [~~CLTS MCO/SE~~] CoLTS MCO/SE is unable to determine liability for, or refuses to pay, a claim from a participating service provider within the times specified above, the [~~CLTS MCO/SE~~] CoLTS MCO/SE shall make a good-faith effort to notify the participating service provider by fax, electronic or other written communication within 30 days of receipt of the claim, stating the specific reasons why it is not liable for the claim, or to request specific information necessary to determine liability for the claim.

D. **Rate setting:** Capitation rates paid by HSD to the [~~CLTS MCO/SE~~] CoLTS MCO/SE for the provision of the [~~coordinated~~] coordination of long-term services 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 a risk basis:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE is at risk of incurring losses if its costs of providing the [~~coordinated~~] coordination of long-term services benefit package exceed its capitation payment. HSD shall not provide retroactive payment adjustments to the [~~CLTS MCO/SE~~] CoLTS MCO/SE to reflect the actual cost of services furnished by the [~~CLTS MCO/SE~~] CoLTS 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; federal requirement for modification of a waiver; 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, or the disproportionate enrollment selection of the contractor by members in a certain rate cohort. Capitation rates may also be adjusted by HSD/MAD based on federal or state appropriation changes.

G. **Solvency requirements and risk protections:** A [~~CLTS MCO/SE~~] CoLTS MCO/SE that contracts with HSD to provide [~~coordinated~~] coordination of long-term 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall be required to meet specific medicaid financial requirements and to provide to HSD the information and records necessary to determine the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's financial condition. Requests for information and records shall be delivered to HSD or its designee, at no cost to HSD, in a reasonable time after the date of request or as specified in the contract.

(1) **Reinsurance:** A [~~CLTS MCO~~] CoLTS MCO participating in the [~~coordinated~~] coordination of long-term services program shall purchase reinsurance at a minimum of [~~one million dollars ($1,000,000.00)~~] $1,000,000.00 in reinsurance protection against financial loss due to outlier (catastrophic) cases. The [~~CLTS MCO~~] CoLTS MCO shall provide documentation to HSD or its designee 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, and other risk-sharing methodologies shall be computed on an actuarially sound basis.

(2) **Third party liability (TPL):** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall be responsible for identifying a member's third party coverage and coordinating benefits with third parties as required by federal law. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall inform HSD or its designee when a member has other health care insurance coverage. The [~~CLTS MCO~~] CoLTS MCO shall have the sole right of subrogation, for 12 months from when it incurred the cost on behalf of the member, 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 for members available to HSD or its designee for audit and review. If the [~~CLTS MCO~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall provide to HSD or its designee for audit and review all records pertaining to TPL collections for its members.

(3) **Fidelity bond requirement:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall maintain a fidelity bond in the maximum amount specified under the Insurance Code.

(4) **Net worth requirement:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall comply with the net worth requirements of the Insurance Code.

(5) **Solvency cash reserve requirement:** The [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE insolvency.

(6) **Per enrollee cash reserve:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall maintain three percent of the monthly capitation payments per member with an independent trustee during each month of the agreement. HSD shall adjust this cash reserve requirement annually, or as needed, based on the number of [~~CLTS MCO/SE~~] CoLTS MCO/SE members, or the failure of the [~~CLTS MCO/SE~~] CoLTS MCO/SE to maintain a cash reserve equal to three percent, and shall notify the [~~CLTS MCO/SE~~] CoLTS MCO/SE of the cash reserve requirement. Each [~~CLTS MCO/SE~~] CoLTS MCO/SE shall maintain its own cash reserve account. This account may be accessed solely for payment of services to the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's members in the event that the [~~CLTS MCO/SE~~] CoLTS MCO/SE becomes insolvent. Money in the reserve account remains the property of the [~~CLTS MCO/SE~~] CoLTS MCO/SE, and any interest earned (even if retained in the account) shall be the property of the [~~CLTS MCO/SE~~] CoLTS MCO/SE. Failure to maintain the reserve as directed above will result in financial penalties equal to the amount of the shortfall in the account each month. If the cash reserve amount exceeds 105 percent of an amount equal to three percent of annualized capitation as determined above for more than two months, HSD will direct the CoLTS MCO/SE to reduce the reserve to the 100 percent level and the CoLTS MCO/SE shall comply with such direction within 90 days.

(7) The [~~CLTS MCO~~] CoLTS MCO may satisfy all or part of the insolvency reserve requirements under Paragraph (6) of Section G of 8.307.11.9 NMAC in writing with evidence of adequate protection through any combination of the following that must be approved by the state: net worth of the [~~CLTS MCO~~] CoLTS MCO (exclusive of any restricted cash reserve); performance guarantee; insolvency insurance; irrevocable letter of credit; surety bond; or a formal written guarantee from the [~~CLTS MCO's~~] CoLTS MCO's parent organization. At least 50 percent of the total insolvency reserve must be restricted cash reserves.

H. **Inspection and audit for solvency requirements:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall meet all requirements for state licensure with respect to inspection and auditing of financial records. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall provide to HSD or its designee all financial records required by HSD. HSD, or its designee, may inspect and audit the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's financial records at least annually or at HSD discretion.

I. **Special payment requirements:** This section lists special payment requirements by service provider type:

(1) **Reimbursement for federally qualified health centers (FQHCs):** Under federal law, FQHCs shall be reimbursed at 100[%] percent of reasonable cost under a medicaid FFS 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 [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE.

(2) **Reimbursement for providers furnishing services to Native Americans:** If an Indian health service (IHS) or tribal 638 provider delivers services to a [~~CLTS MCO/SE member who is Native American, the CLTS MCO/SE~~] CoLTS MCO/SE member, the CoLTS MCO/SE shall reimburse the provider at the rate established by the office of management and budget (OMB) for specified services at IHS facilities, [~~except when otherwise specified by HSD.~~] and tribal 638 providers. Pharmacy, inpatient physician, case management and ambulatory surgical center services shall be paid at the fee schedule established by HSD. Services reimbursed at the OMB rate are not subject to prior authorization.

(3) **Reimbursement for family planning services:** The [~~CLTS MCO~~] CoLTS MCO shall reimburse out-of-network family planning providers for services provided to its members at a rate at least equal to the medicaid FFS 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 coordinated long-term services has an established relationship with an obstetrical provider and desires to continue that relationship, and the provider is not contracted with the [~~CLTS MCO~~] CoLTS MCO, the [~~CLTS MCO~~] CoLTS MCO shall reimburse the out-of-network provider for services directly related to the pregnancy, including delivery and [~~a six-week post-partum visit~~] and two months of post-partum related care.

(5) **Reimbursement for members who disenroll while hospitalized:** [~~If a medicaid member is hospitalized at the time of disenrollment, the organization that was originally responsible for the hospital impatient 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 CoLTS MCO and medicaid fee-for-service (FFS) members: If a CoLTS MCO or FFS member is hospitalized at the time of enrollment into or disenrollment from managed care or upon an approved switch from one CoLTS MCO to another, the originating CoLTS 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 CoLTS from Salud! or from CoLTS to Salud!, 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:** HSD may impose financial penalties or sanctions against a [~~CLTS MCO/SE~~] CoLTS MCO/SE that fails to meet the financial requirements specified in this section or additional requirements specified in the terms of the medicaid [~~coordinated~~] coordination of long-term services contract or federal medicaid law.

J. **Recoupment payments:** HSD shall recoup payments for [~~CLTS MCO~~] CoLTS MCO members who are incorrectly enrolled with more than one [~~CLTS MCO~~] CoLTS MCO, payments made for [~~CLTS MCO/SE~~] CoLTS MCO/SE members who die prior to the enrollment month for which payment was made; or payments to the [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE or HSD shall be recouped upon identification. In the event of an error that causes payment(s) to the [~~CLTS MCO/SE~~] CoLTS MCO/SE to be issued by HSD, HSD shall recoup the full amount of the payment. HSD shall provide the [~~CLTS MCO/SE~~] CoLTS MCO/SE with a detailed listing of specific members and the associated recoupment for each on a monthly basis, if applicable. 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 recoupment procedures shall be discussed in advance by HSD and the [~~CLTS MCO/SE~~] CoLTS MCO/SE, and documented in writing prior to implementation of the new automated recoupment process. The [~~CLTS MCO/SE~~] CoLTS MCO/SE has the right to dispute any recoupment action in accordance with contractual provisions.

K. HSD shall pay interest at nine percent per annum on any capitation payment due to the [~~CLTS MCO/SE~~] CoLTS 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 an alternate payment methodology for specified program services or responsibilities.

[8.307.11.9 NMAC - N, 8-1-08; A, 9-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.307.12 NMAC, sections 6 and 8-15, effective September 1, 2009.

8.307.12.6 OBJECTIVE: The objective of these [~~regulations~~] rules is to provide policies for the service portion of the New Mexico medicaid [~~coordinated~~] coordination of long-term services program.

[8.307.12.6 NMAC - N, 8-1-08; A, 9-1-09]

8.307.12.8 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. [8.307.12.8 NMAC - N, 8-1-08; A, 9-1-09]

8.307.12.9 GENERAL REQUIREMENTS FOR GRIEVANCES AND APPEALS:

A. The [~~coordinated~~] coordination of long-term services managed care organization [~~(CLTS MCO)~~] (CoLTS MCO) and single statewide entity (SE) shall have a grievance system in place for members that includes a grievance process related to dissatisfaction and an appeals process related to a [~~CLTS MCO/SE~~] CoLTS MCO/SE action, including the opportunity to request a human services department (HSD) fair hearing.

B. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall implement written policies and procedures describing how the member may submit a request for a grievance or an appeal with the [~~CLTS MCO/SE~~] CoLTS MCO/SE , or submit a request for a fair hearing with HSD. The policy shall include a description of how the [~~CLTS MCO/SE~~] CoLTS MCO/SE resolves the grievance or appeal.

C. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall provide to all service providers in the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's network a written description of its grievance and appeal process and how providers can submit a grievance or appeal for a member or on their own behalf.

D. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall make 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall name a specific individual(s) designated as the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's medicaid member grievances or appeals coordinator with the authority to administer the policies and procedures for resolution of a grievance or appeal, to review patterns/trends in grievances or appeals, and to initiate corrective action.

F. The [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall also ensure that health care professionals with appropriate clinical expertise shall make decisions for the following:

(1) an appeal of a [~~CLTS MCO/SE~~] CoLTS MCO/SE denial that is based on lack of medical necessity;

(2) a [~~CLTS MCO/SE~~] CoLTS MCO/SE denial that is upheld in an expedited resolution; and

(3) a grievance or appeal that involves clinical issues.

G. Upon enrollment, the [~~CLTS MCO/SE~~] CoLTS 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 fair hearings bureau, upon notification of a [~~CLTS MCO/SE~~] CoLTS MCO/SE action, or concurrent with, subsequent to or in lieu of an appeal of the [~~CLTS MCO/SE~~] CoLTS MCO/SE action. The information shall meet the standards specified in Paragraph (12) of Subsection A of 8.307.8.15 NMAC, *members' rights*.

H. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall ensure that punitive or retaliatory action is not taken against a member or service provider that files a grievance or an appeal, or a provider that supports a member's grievance or appeal. [8.307.12.9 NMAC - N, 8-1-08; A, 9-1-09]

8.307.12.10 GRIEVANCE: A grievance is an expression of dissatisfaction about any matter or aspect of the [~~CLTS MCO/SE~~] CoLTS MCO/SE or its operation, other than a [~~CLTS MCO/SE~~] CoLTS MCO/SE action.

A. A member may file a grievance either orally or in writing with the [~~CLTS MCO/SE~~] CoLTS MCO/SE within 90 calendar days of the date of the event causing the dissatisfaction. The legal guardian of the member for a minor or an incapacitated adult, a representative of the member as designated in writing to the [~~CLTS MCO/SE~~] CoLTS MCO/SE, or a service provider acting on behalf of the member and with the member's written consent, have the right to file a grievance on behalf of the member.

B. Within five working days of receipt of the grievance, the [~~CLTS MCO/SE~~] CoLTS MCO/SE shall provide the grievant with written notice that the grievance has been received and the expected date of its resolution.

C. The investigation and final [~~CLTS MCO/SE~~] CoLTS MCO/SE resolution process for grievances shall be completed within 30 calendar days of the date the grievance is received by the [~~CLTS MCO/SE~~] CoLTS MCO/SE and shall include a resolution letter to the grievant.

D. The [~~CLTS MCO/SE~~] CoLTS MCO/SE may request an extension from HSD or its designee of up to 14 calendar days if the member requests the extension, or the [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall give the member written notice of the reason for the extension within two working days of the decision to extend the timeframe.

E. Upon resolution of the grievance, the [~~CLTS MCO/SE~~] CoLTS MCO/SE shall mail a resolution letter to the member. This resolution letter may not take the place of the acknowledgment letter referred to in Section B of 8.307.12.10 NMAC above. The resolution letter shall include, but not be limited to, the following:

(1) all information considered in investigating the grievance;

(2) findings and conclusions based on the investigation; and

(3) the disposition of the grievance. [8.307.12.10 NMAC - N, 8-1-08; A, 9-1-09]

8.307.12.11 APPEALS: An appeal is a request for review by the [~~CLTS MCO/SE~~] CoLTS MCO/SE of a [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE to provide services in a timely manner, as defined by HSD or its designee; or

(5) the failure of the [~~CLTS MCO/SE~~] CoLTS MCO/SE to complete the authorization request in a timely manner as defined in 42 CFR 438.408.

B. **Notice of [~~CLTS MCO/SE~~] CoLTS MCO/SE action:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall mail a notice of action to the member or service 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 date 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE has taken or intends to take;

(2) the reasons for the action;

(3) the member's or the service provider's right, as applicable, to file an appeal of the [~~CLTS MCO/SE~~] CoLTS MCO/SE action through the [~~CLTS MCO/SE~~] CoLTS 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; 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. A member may file an appeal of a [~~CLTS MCO/SE~~] CoLTS MCO/SE action within 90 calendar days of receiving the [~~CLTS MCO's/SE's~~] CoLTS MCO's/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 [~~CLTS MCO/SE~~] CoLTS MCO/SE, or a service 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall consider the member, representative, or estate representative of a deceased member as parties to the appeal.

D. The [~~CLTS MCO/SE~~] CoLTS MCO/SE has 30 calendar days from the date the initial oral or written appeal is received by the [~~CLTS MCO/SE~~] CoLTS MCO/SE to resolve the appeal. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall appoint at least one person to review the appeal who was not involved in the initial decision and who is not the subordinate of any person involved in the initial decision.

E. The [~~CLTS MCO/SE~~] CoLTS 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 that is signed by the member within 10 calendar days. The [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall provide the grievant with written notice that the appeal has been received and the expected date of its resolution. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall confirm in writing receipt of oral appeals, unless the member or the service provider requests an expedited resolution.

G. The [~~CLTS MCO/SE~~] CoLTS MCO/SE may extend the 30-day timeframe by 14 calendar days if the member requests the extension, or the [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall provide written notice within the 30-calendar-day timeframe for resolutions to the member or the service 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 and reasoning behind 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 [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's action.

K. The [~~CLTS MCO/SE~~] CoLTS MCO/SE may continue benefits while the appeal or the HSD fair hearing process is pending.

(1) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall continue the member's benefits if all of the following are met:

(a) the member or the service provider files a timely appeal of the [~~CLTS MCO/SE~~] CoLTS MCO/SE action or the member asks for a fair hearing within 13 days from the date on the [~~CLTS MCO/SE~~] CoLTS 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 service provider;

(d) the time period covered by the original authorization has not expired; and

(e) the member requests extension of the benefits.

(2) The [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's action is upheld, the [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

(5) If the [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall pay for these services. [8.307.12.11 NMAC - N, 8-1-08; A, 9-1-09]

8.307.12.12 EXPEDITED RESOLUTION OF APPEALS: An expedited resolution of an appeal is an expedited review by the [~~CLTS MCO/SE~~] CoLTS MCO/SE of a [~~CLTS MCO/SE~~] CoLTS MCO/SE action.

A. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall establish and maintain an expedited review process for appeals when the [~~CLTS MCO/SE~~] CoLTS MCO/SE determines that allowing the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Such a determination is based on:

(1) a request from the member;

(2) a service provider's support of the member's request;

(3) a service provider's request on behalf of the member; or

(4) the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's independent determination.

B. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall ensure that the expedited review process is convenient and efficient for the member.

C. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall resolve the appeal within three working days of receipt of the request for an expedited appeal, if the request meets the definition of expedited in 8.307.12.13 NMAC, *expedited resolution of appeals*. In addition to written resolution notice, the [~~CLTS MCO/SE~~] CoLTS MCO/SE shall also make reasonable efforts to provide and document oral notice.

D. The [~~CLTS MCO/SE~~] CoLTS MCO/SE may extend the timeframe by up to 14-calendar days if the member requests the extension, or the [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall give the member written notice of the reason for the delay.

E. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall ensure that punitive action is not taken against a member or a service provider who requests an expedited resolution or supports a member's expedited appeal.

F. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall provide an expedited resolution, if the request meets the definition of an expedited appeal, in response to an oral or written request from the member or service provider on behalf of the member.

G. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall inform the member of the limited time available to present evidence and allegations in fact or law.

H. If the [~~CLTS MCO/SE~~] CoLTS MCO/SE denies a request for an expedited resolution of an appeal, it shall:

(1) transfer the appeal to the 30-day timeframe for standard resolution, in which the 30-day period begins on the date the [~~CLTS MCO/SE~~] CoLTS MCO/SE received the original request for appeal; and

(2) make reasonable efforts to give the member prompt oral notice of the denial, and follow up with a written notice within two-calendar days.

I. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.

[8.307.12.12 NMAC - N, 8-1-08; A, 9-1-09]

8.307.12.13 SPECIAL RULE FOR CERTAIN EXPEDITED SERVICE AUTHORIZATION DECISIONS: In the case of expedited service authorization decisions that deny or limit services, the [~~CLTS MCO/SE~~] CoLTS MCO/SE shall, within 72 hours of receipt of the request for service, automatically file an appeal on behalf of the member, use its best effort, to give the member oral notice of the decision on the automatic appeal and to resolve the appeal.

[8.307.12.13 NMAC - N, 8-1-08; A, 9-1-09]

8.307.12.14 OTHER RELATED PROCESSES:

A. **Information about grievance system to providers and subcontractors**: The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall provide information specified in 42 CFR 438.10(g)(1) about the grievance system to all service providers and subcontractors at the time they enter into a contract.

B. **Grievance or appeal files:**

(1) All grievance or appeal files shall be maintained in a secure and designated area and be accessible to HSD or its designee, upon request, for review. Grievance or appeal files shall be retained for 10 years following the final decision by the [~~CLTS MCO/SE~~] CoLTS MCO/SE, HSD, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later.

(2) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have procedures for assuring that files contain sufficient information to identify the grievance or appeal, the date it was received, the nature of the grievance or appeal, notice to the member of receipt of the grievance or appeal, all correspondence between the [~~CLTS MCO/SE~~] CoLTS MCO/SE and the member, the date the grievance or appeal is resolved, the resolution, the notices of final decision to the member, and all other pertinent information.

(3) Documentation regarding the grievance shall be made available to the member, if requested.

[8.307.12.14 NMAC - N, 8-1-08; A, 9-1-09]

8.307.12.15 PROVIDER GRIEVANCE AND APPEAL PROCESS: The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall establish and maintain written policies and procedures for the filing of provider grievances and appeals. A service provider shall have the right to file a grievance or an appeal with the [~~CLTS MCO/SE~~] CoLTS MCO/SE. Provider grievances or appeals shall be resolved within 30-calendar days. If the grievance or appeal is not resolved within 30 days, the [~~CLTS MCO/SE~~] CoLTS MCO/SE shall request a 14-day extension from the service provider. If the service provider requests the extension, the extension shall be approved by the [~~CLTS MCO/SE~~] CoLTS MCO/SE. A service provider may not file a grievance or an appeal on behalf of a member without written designation by the member as the member's representative. A service provider shall have the right to file an appeal with the [~~CLTS MCO/SE~~] CoLTS MCO/SE regarding provider payment or contractual issues. See 8.307.12.13 NMAC for special rules for certain expedited service authorizations.

[8.307.12.15 NMAC - N, 8-1-08; A, 9-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.307.13 NMAC, sections 6, 8, 9 and 10, effective September 1, 2009.

8.307.13.6 OBJECTIVE: The objective of these [~~regulations~~] rules is to provide policies for the service portion of the New Mexico medicaid [~~coordinated~~] coordination of long-term services program.

[8.307.13.6 NMAC - N, 8-1-08; A, 9-1-09]

8.307.13.8 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.

[8.307.13.8 NMAC - N, 8-1-08; A, 9-1-09]

8.307.13.9 FRAUD AND ABUSE: The human services department (HSD) is committed to the development and implementation of an aggressive prevention, detection, monitoring and investigation program to reduce provider/member fraud and abuse, and member abuse and neglect. If fraud or abuse is discovered, HSD shall seek applicable administrative, civil and criminal penalties, sanctions and other forms of relief. This applies to all individuals participating in or contracting with HSD for provision or receipt of medicaid services. The [~~coordinated~~] coordination of long-term services managed care organization [~~(CLTS MCO)~~] (CoLTS MCO) and single statewide entity (SE) shall comply with provisions of state and federal fraud and abuse laws and regulations.

[8.307.13.9 NMAC – N, 8-1-08; A, 9-1-09]

8.307.13.10 [~~COORDINATED~~] COORDINATION OF LONG-TERM SERVICES MANAGED CARE ORGANIZATION REQUIREMENTS: The [~~CLTS MCO/SE~~] CoLTS 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 service providers and members. The [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's 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 or its designee. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall maintain procedures for reporting potential and actual fraud and abuse by consumers or service providers to HSD or its designee. The [~~CLTS MCO/SE~~] CoLTS 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 preventing and detecting potential cases of fraud and abuse, such as claims edits, post processing review of claims, service provider profiling/exception reporting and credentialing, prior authorizations, and 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 [~~coordinated~~] coordination of long-term services;

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 or its designee the names of all service providers identified with aberrant utilization, according to service provider profiles, regardless of the cause of the aberrancy;

F. designate a compliance officer and a compliance committee that are accountable to senior management;

G. provide effective fraud and abuse detection training, administrative remedies for false claims and statements, and whistleblower protection under such laws to the [~~CLTS MCO's/SE's~~] CoLTS MCO's/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) as part of such written policies, detailed provision regarding the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE'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 or subcontractor's policies and procedures for detecting and preventing fraud, waste and abuse;

H. implement effective lines of communication between the compliance officer and the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's employees;

I. require enforcement of standards through well-publicized disciplinary guidelines; and

J. have a provision for prompt response to detected offenses and for development of corrective action initiatives relating to the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's contract.

[8.307.13.10 NMAC - N, 8-1-08; A, 9-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.307.14 NMAC, sections 6 and 8-12, effective September 1, 2009.

8.307.14.6 OBJECTIVE: The objective of these [~~regulations~~] rules is to provide policies for the service portion of the New Mexico medicaid [~~coordinated~~] coordination of long-term services program.

[8.307.14.6 NMAC - N, 8-1-08; A, 9-1-09]

8.307.14.8 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.

[8.307.14.8 NMAC - N, 8-1-08; A, 9-1-09]

8.307.14.9 REPORTING REQUIREMENTS: The [~~coordinated~~] coordination of long-term services managed care organization [~~(CLTS MCO)~~] (CoLTS MCO) and single statewide entity (SE) shall provide to the human services department (HSD) managerial, financial, delegation, suspicious activity, utilization, and quality reports. The content, format and schedule for submission shall be determined by HSD or its designee in writing. HSD or its designee may require the [~~CLTS MCO/SE~~] CoLTS MCO/SE to prepare and submit ad hoc reports.

[8.307.14.9 NMAC - N, 8-1-08; A, 9-1-09]

8.307.14.10 REPORTING STANDARDS:

A. Reports submitted by the [~~CLTS MCO/SE~~] CoLTS MCO/SE to HSD shall meet certain standards.

(1) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall verify the accuracy of data and other information on reports submitted.

(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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall analyze all required reports internally before submitting them to HSD or its designee. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall analyze reports for any early patterns of change, identified trends, or outliers (catastrophic cases), and shall submit this analysis with the required reports. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall send a written narrative for specified reports with the report documenting the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's interpretation of early patterns of change, identified trends, or outliers.

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 [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall comply with changes specified by HSD or its designee.

[8.307.14.10 NMAC - N, 8-1-08; A, 9-1-09]

8.307.14.11 MANAGERIAL REPORTS: Managerial reports demonstrate compliance with the operational requirements of the contract. These reports shall include, but not be limited to, information on such topics as:

A. [~~CLTS MCO/SE~~] CoLTS MCO/SE: composition of current provider networks and capacity to take new members;

B. [~~CLTS MCO/SE~~] CoLTS MCO/SE: changes in the composition and capacity of provider networks;

C. [~~CLTS MCO/SE~~] CoLTS MCO: primary care provider (PCP)-to-member ratios;

D. [~~CLTS MCO/SE~~] CoLTS MCO/SE: identification of third-party liability;

E. [~~CLTS MCO/SE~~] CoLTS MCO/SE: grievance system activity;

F. [~~CLTS MCO/SE~~] CoLTS MCO/SE: fraud and abuse detection activities;

G. [~~CLTS MCO/SE~~] CoLTS MCO/SE: delegation oversight activities; and

H. [~~CLTS MCO/SE~~] CoLTS MCO/SE: member satisfaction.

[8.307.14.11 NMAC - N, 8-1-08; A, 9-1-09]

8.307.14.12 FINANCIAL REPORTS: Financial reports demonstrate the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's ability to meet its commitments under the terms of the contract. The format, content and frequency for submitting financial reports shall be determined by HSD or its designee. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall meet the following general requirements:

A. The [~~CLTS MCO~~] CoLTS MCO shall submit annual audited financial statements, including, but not limited to, its income statement, a statement of changes in financial condition or cash flow and a balance sheet, and shall include an audited schedule of [~~coordinated~~] coordination of long-term services revenues and expenses. The SE shall submit annual audited financial statements, including, but not limited to, its income statement, a statement of changes in financial condition or cash flow and a balance sheet, and shall include an audited schedule of [~~coordinated~~] coordination of long-term services behavioral health revenues and expenses. The result of the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's annual audit and related management letters shall be submitted no later than 150 days following the close of the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's fiscal year. The audit shall be performed by an independent certified public accountant. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall submit for examination any financial reports requested by HSD or its designee.

B. The [~~CLTS MCO/SE~~] CoLTS MCO/SE and their subcontractors shall maintain their accounting systems in accordance with statutory accounting principles, generally accepted accounting principles, or other generally accepted systems of accounting. The accounting system shall clearly document all financial transactions between the [~~CLTS MCO/SE~~] CoLTS MCO/SE and their subcontractors and the [~~CLTS MCO/SE~~] CoLTS MCO/SE and HSD. These transactions shall include, but not be limited to, claim payments, refunds and adjustments of payments.

C. The [~~CLTS MCO/SE~~] CoLTS MCO/SE and their subcontractors shall make available to HSD, and other authorized state or federal agencies, all financial records required to examine compliance by the [~~CLTS MCO/SE~~] CoLTS MCO/SE, in so far as those records are related to [~~CLTS MCO/SE~~] CoLTS MCO/SE performance under the contract. The [~~CLTS MCO/SE~~] CoLTS MCO/SE and their subcontractors shall provide HSD or its designee access to their facilities for the purpose of examining, reviewing and inspecting the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's records.

D. The [~~CLTS MCO/SE~~] CoLTS MCO/SE and their subcontractors shall retain all records and reports relating to agreements with HSD for a minimum of 10 years after the date of final payment. In cases involving incomplete audits and unresolved audit findings, administrative sanctions or litigation, the minimum 10-year retention period shall begin on the date such actions are resolved.

E. The [~~CLTS MCO/SE~~] CoLTS MCO/SE is mandated to notify HSD or its designee immediately when any change in ownership is anticipated. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall submit a detailed work plan to the department of insurance during the transition period no later than the date of the sale. The work plan shall identify areas of the contract that may be impacted by the change in ownership, including management and staff. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall submit records involving any business restructuring when changes in ownership interest in the [~~CLTS MCO/SE~~] CoLTS MCO/SE of five percent or more have occurred. These records shall include, but not be limited to, an updated list of names and addresses of all persons or entities having ownership interest in the [~~CLTS MCO/SE~~] CoLTS MCO/SE of five percent or more. These records shall be provided no later than 60 days following the change in ownership.

[8.307.14.12 NMAC - N, 8-1-08; A, 9-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.307.15 NMAC, sections 6 and 8-21, effective September 1, 2009.

8.307.15.6 OBJECTIVE: The objective of these [~~regulations~~] rules is to provide policies for the service portion of the New Mexico medicaid [~~coordinated~~] coordination of long-term services program.

[8.307.15.6 NMAC - N, 8-1-08; A, 9-1-09]

8.307.15.8 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.

[8.307.15.8 NMAC - N, 8-1-08; A, 9-1-09]

8.307.15.9 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 [~~CLTS MCO/SE~~] CoLTS 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have written policies and procedures in place, with the human services department's (HSD's) or its designee's approval, that govern how members with multiple and complex physical and behavioral health service needs shall be identified. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have an internal operational process, in accordance with policies and procedures, to target members for the purpose of applying stratification criteria to identify ISHCN. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall employ reasonable efforts to identify ISHCN based at least on the following criteria:

(1) individuals eligible for supplemental security income (SSI);

(2) individuals enrolled in the home-based waiver programs;

(3) children receiving foster care or adoption assistance support;

(4) individuals identified by service utilization, clinical assessment, or diagnosis; and

(5) referral by family or a public or community program.

[8.307.15.9 NMAC - N, 8-1-08; A, 9-1-09]

8.307.15.10 [~~COORDINATED~~] COORDINATION OF LONG-TERM SERVICES ENROLLMENT FOR ISHCN:

A. **Switch enrollment:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have policies and procedures to facilitate a smooth transition for members

who switch enrollment to another [~~CLTS MCO~~] CoLTS MCO. See Subsection G of 8.307.5.9 NMAC, *member switch enrollment*. Members, including ISHCN, may request to break a lock-in and be switched to membership in another [~~CLTS MCO~~] CoLTS MCO, based on cause. The member or the member's family or legal guardian shall contact HSD or its designee to request that the member be switched to another [~~CLTS MCO~~] CoLTS MCO.

B. **ISHCN information and education:**

(1) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall develop and distribute information and materials specific to the needs of ISHCN to ISHCN members, caregivers, and parents or legal guardians, as appropriate. This includes information such as items and services that are provided or not provided by the [~~coordinated~~] coordination of long-term services program, how to arrange transportation, and which services require a referral from the member's primary care provider (PCP). The individual, family, caregiver, or legal guardian shall be informed on how to present an individual for services in an emergency room that is unfamiliar with the individual's special health service needs, and about the availability of service coordination. See 8.307.9 NMAC, *Coordination of Services*. This information may be included in either a special member handbook or in an ISHCN insert to the [~~CLTS MCO/SE~~] CoLTS MCO/SE member handbook.

(2) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall provide health education information to assist an ISCHN or caregivers in understanding how to cope with the day-to-day stress caused by chronic illness, including chronic behavioral health conditions.

(3) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall provide ISHCN or caregivers a list of key [~~CLTS MCO/SE~~] CoLTS MCO/SE resource people and their telephone numbers. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall designate a single point of contact that an ISHCN member, family member, caregiver, or service provider may call for information.

[8.307.15.10 NMAC - N, 8-1-08; A, 9-1-09]

8.307.15.11 CHOICE OF SPECIALIST AS PCP: The [~~CLTS MCO~~] CoLTS MCO shall develop and implement policies and procedures governing the process for member selection of a PCP, including the right by an ISHCN to choose a specialist as a PCP. The specialist provider must agree to be the PCP.

[8.307.15.11 NMAC - N, 8-1-08; A, 9-1-09]

8.307.15.12 SPECIALTY PROVIDERS FOR ISHCN: The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have policies and procedures in place to allow direct access to necessary specialty services, consistent with [~~coordinated~~] coordination of long-term services access appointment standards for clinical urgency, including behavioral health access standards. See 8.307.8.18 NMAC, s*tandards for access*.

[8.307.15.12 NMAC - N, 8-1-08; A, 9-1-09]

8.307.15.13 TRANSPORTATION FOR ISHCN: The [~~CLTS MCO~~] CoLTS MCO shall:

A. have written policies and procedures in place to ensure that the appropriate level of transportation is arranged, based on the individual's clinical condition;

B. have past member service data available at the time services are requested to expedite appropriate arrangement;

C. ensure that CPR-certified drivers transport ISHCN if clinically indicated;

D. have written policies and procedures to ensure that the transportation mode is clinically appropriate, including access to non-emergency ground carriers;

E. develop and implement written policies and procedures to ensure that individuals can access and receive authorization for needed transportation services under certain unusual circumstances without the usual advance notification;

F. develop and implement a written policy regarding the transportation of minors to ensure the minor's safety;

G. distribute clear and detailed written information to ISHCN and, if needed, to their caregivers, on how to obtain transportation services, and also make this information available to network providers; and

H. coordinate transportation needs with the SE; the SE shall also coordinate the transportation needs of its population with the member's respective [~~CLTS MCO~~] CoLTS MCO.

[8.307.15.13 NMAC - N, 8-1-08; A, 9-1-09]

8.307.15.14 SERVICE COORDINATION FOR ISHCN: The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall develop policies and procedures to provide service coordination for ISHCN. Refer to Section 8.307.9.9 NMAC, *coordination of services*, for definition.

A. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have an internal operational process, in accordance with policies and procedures, to target medicaid members for purposes of applying stratification criteria to identify those who are potential ISHCN. The contractor shall provide HSD or its designee with the applicable policies and procedures describing the targeting and stratification process.

B. The [~~CLTS MCO/SE~~] CoLTS 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 service coordination. If the member has both physical and behavioral health special needs, the [~~CLTS MCO~~] CoLTS MCO and SE shall coordinate services in a timely and collaborative manner.

C. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have written policies and procedures for educating ISHCN needs and, in the case of children with special health care needs, parent and legal guardians, that service coordination is available and when it may be appropriate to their needs.

[8.307.15.14 NMAC - N, 8-1-08; A, 9-1-09]

8.307.15.15 EMERGENCY, INPATIENT AND OUTPATIENT AMBULATORY SURGERY HOSPITAL REQUIREMENTS FOR ISHCN: The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall develop and implement policies and procedures for:

A. educating ISHCN members, ISHCN family members or caregivers on how to access emergency room services and what clinical history to provide when emergency services or inpatient admission are needed, including behavioral health emergency services;

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 clinical history; and

D. obtaining any necessary referrals from PCPs for inpatient hospital staff providing outpatient or ambulatory surgical procedures.

[8.307.15.15 NMAC - N, 8-1-08; A, 9-1-09]

8.307.15.16 REHABILITATION THERAPY SERVICES (PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY) FOR ISHCN: The [~~CLTS MCO~~] CoLTS MCO shall:

A. develop and implement therapies using clinical practice guidelines specific to acute, chronic or long-term conditions of their ISHCN, that meet medical necessity criteria and are based on HSD's children and adult rehabilitation services policy;

B. be knowledgeable about and coordinate with the home and community-based waiver programs or the schools regarding other therapy services being provided to the ISHCN in order to avoid duplication of services;

C. involve the ISHCN's

family, caregivers, physicians and therapy service providers in identifying issues to be included in the plan of services; and

D. develop and implement utilization prior authorization and continued stay criteria, including time frames, that are appropriate to the chronicity of the member's status and anticipated development process.

[8.307.15.16 NMAC - N, 8-1-08; A, 9-1-09]

8.307.15.17 DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES FOR ISHCN: The [~~CLTS MCO~~] CoLTS MCO shall:

A. develop and implement a process to permit members utilizing supplies on an ongoing basis to submit a list of supplies to the DME service provider on a monthly basis; the [~~CLTS MCO~~] CoLTS MCO shall contact the member or the member's legal guardian or caregiver when requested supplies cannot be delivered and make other arrangements, consistent with clinical need;

B. develop and implement a system for monitoring compliance with access standards for DME and medical supplies, and institute corrective action if the service provider is out of compliance; and

C. have an emergency response plan for DME and medical supplies needed on an emergent basis.

[8.307.15.17 NMAC - N, 8-1-08; A, 9-1-09]

8.307.15.18 CLINICAL PRACTICE GUIDELINES FOR PROVISION OF SERVICES TO ISHCN: The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall develop clinical practice guidelines, practice parameters and other criteria that consider the needs of ISHCN and provide guidance in the provision of acute and chronic physical and behavioral health care services to this population. The guidelines should be based on professionally accepted standards of practice and national guidelines.

[8.307.15.18 NMAC - N, 8-1-08; A, 9-1-09]

8.307.15.19 UTILIZATION MANAGEMENT FOR SERVICES TO ISHCN: The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall develop written policies and procedures to exclude from prior authorization any item of service identified in the course of treatment or extend the authorization periodicity for services provided for chronic conditions. There shall be a process for review and periodic update for the course of treatment, as indicated.

[8.307.15.19 NMAC - N, 8-1-08; A, 9-1-09]

8.307.15.20 ADDITIONS TO CONSUMER ASSESSMENT OF HEALTH PLANS SURVEY (CAHPS) FOR ISHCN: The [~~CLTS MCO~~] CoLTS MCO shall add questions about ISHCN to the most current health plan employer data and information set (HEDIS) CAHPS survey.

[8.307.15.20 NMAC - N, 8-1-08; A, 9-1-09]

8.307.15.21 ISHCN PERFORMANCE MEASURES: The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall initiate a quality strategy related to ISHCN within its annual quality management plan utilizing a performance measure specific to ISHCN. See 8.307.8 NMAC, *Quality Management*.

[8.307.15.21 NMAC - N, 8-1-08; A, 9-1-09]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.307.16 NMAC, sections 6, 8 and 9, effective September 1, 2009.

8.307.16.6 OBJECTIVE: The objective of these [~~regulations~~] rules is to provide policies for the service portion of the New Mexico medicaid [~~coordinated~~] coordination of long-term services program.

[8.307.16.6 NMAC - N, 8-1-08; A, 9-1-09]

8.307.16.8 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.

[8.307.16.8 NMAC - N, 8-1-08; A, 9-1-09]

8.307.16.9 MEMBER TRANSITION OF SERVICES: The [~~coordinated~~] coordination of long-term services managed care organization [~~(CLTS MCO)~~] (CoLTS MCO) and single statewide entity (SE) shall have the resources, policies and procedures in place to ensure continuity of services without disruption in service to members and to assure the service provider of payment. The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall actively assist members, in particular individuals with special health care needs (ISHCN). Members transitioning from institutional levels of care such as hospitals, nursing homes, or residential treatment facilities back to community services with transition of service needs shall be offered care coordination services as indicated. Medicaid-eligible members may initially receive physical and behavioral health services under fee-for-service (FFS) medicaid prior to enrollment in [~~coordinated~~] coordination of long-term services. During the member's medicaid eligibility period, enrollment status with a particular [~~CLTS MCO~~] CoLTS MCO may change and the member may switch enrollment to a different [~~CLTS MCO~~] CoLTS MCO. Certain members covered under [~~coordinated~~] coordination of long-term services may become exempt and other members may lose their medicaid eligibility while enrolled in a [~~CLTS MCO/SE~~] CoLTS MCO/SE. A member changing from one [~~CLTS MCO~~] CoLTS MCO to another [~~CLTS MCO~~] CoLTS MCO, or from FFS to [~~coordinated~~] coordination of long-term services or vice versa shall continue to receive medically necessary services in an uninterrupted manner.

A. **Member transition:** The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have policies and procedures that address member identification and the clinical transition and transfer of members into or out of the [~~CLTS MCO~~] CoLTS MCO.

(1) The [~~CLTS MCO~~] CoLTS MCO shall have policies and procedures that cover potentially large or mass transfer of members into or out of the [~~CLTS MCO~~] CoLTS MCO, including the identification of members currently receiving services, and notification of the statewide entity (SE).

(2) The [~~CLTS MCO~~] CoLTS MCO shall have policies and procedures that address the transition into the [~~CLTS MCO~~] CoLTS MCO of an individual member, including member and provider education about the [~~CLTS MCO~~] CoLTS MCO and the review and update of existing courses of treatment. The SE shall be notified and coordination of care shall occur.

(3) The [~~CLTS MCO~~] CoLTS MCO shall have policies and procedures that identify members transferring out of the [~~CLTS MCO~~] CoLTS MCO and ensure the provision of member data and clinical information to the future [~~CLTS MCO~~] CoLTS MCO necessary to avoid delays in member treatment. The [~~CLTS MCO~~] CoLTS MCO shall have written policies and procedures to facilitate a smooth transition of a member to another [~~CLTS MCO~~] CoLTS MCO when a member chooses and is approved to switch to another [~~CLTS MCO~~] CoLTS MCO.

(4) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall have policies and procedures regarding provider responsibilities for discharge planning upon the member's discharge from an inpatient or residential treatment facility, and the [~~CLTS MCO/SE~~] CoLTS MCO/SE shall help coordinate for a seamless transition of post-discharge care.

B. **Prior authorization and provider payment requirements:**

(1) For newly enrolled members, the [~~CLTS MCO~~] CoLTS MCO shall honor all prior authorizations granted by the human services department (HSD) through its contractors, including the SALUD! contractors, for the first 60 days of enrollment or until the [~~CLTS MCO~~] CoLTS MCO has made other arrangements

for the transition of services. Providers who delivered services approved by HSD through its contractors shall be reimbursed by the [~~CLTS MCO~~] CoLTS MCO. The SE shall honor all prior authorizations for 30 days or until other arrangements can be made.

(2) For members who recently became exempt from [~~coordinated~~] coordination of long-term services, HSD shall honor prior authorization of FFS covered benefits granted by the [~~CLTS MCO/SE~~] CoLTS MCO/SE for the first 30 days under FFS medicaid or until other arrangements for the transition of services have been made. Providers that deliver these services and are eligible and willing to enroll as medicaid FFS providers shall be reimbursed by HSD.

(3) For members who had transplant services approved by HSD under FFS, the [~~CLTS MCO~~] CoLTS MCO shall reimburse the service providers approved by HSD if a donor organ becomes available for the member during the first 30 days of enrollment.

(4) For members who had transplant services approved by the [~~CLTS MCO~~] CoLTS MCO, HSD shall reimburse the service providers approved by the [~~CLTS MCO~~] CoLTS MCO if a donor organ becomes available for the member during the first 30 days under FFS medicaid. Service providers who deliver these services shall be eligible and willing to enroll as medicaid FFS providers.

(5) For newly enrolled members, the [~~CLTS MCO~~] CoLTS MCO shall pay for prescriptions for drug refills for the first 90 days or until the [~~CLTS MCO~~] CoLTS MCO has made other arrangements. The SE shall pay for all prescriptions for 30 days or until other arrangements are made. All drugs prescribed by a licensed behavioral health service provider shall be paid for by the SE.

(6) For members who recently became exempt from [~~coordinated~~] coordination of long-term services, HSD shall pay for prescriptions for drug refills for the first 30 days under the FFS formulary. The pharmacy provider shall be eligible and willing to enroll as a medicaid FFS provider.

(7) The [~~CLTS MCO~~] CoLTS MCO shall pay for durable medical equipment (DME) costing $2,000 or more, approved by the [~~CLTS MCO~~] CoLTS MCO but delivered to the member after disenrollment from [~~coordinated~~] coordination of long-term services.

(8) HSD shall pay for DME costing $2,000 or more, approved by HSD but delivered to the member after enrollment in the [~~CLTS MCO~~] CoLTS MCO. The DME service provider shall be eligible for and willing to enroll as a medicaid FFS provider. DME is not covered by the SE unless it has been prescribed by a behavioral health service provider.

C. **Special payment requirement:** The [~~CLTS MCO~~] CoLTS MCO shall be responsible for payment of covered physical health services provided to the member for any month during which the [~~CLTS MCO~~] CoLTS 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 the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's contract with HSD or the collaborative has ended, is not renewed or is terminated, the [~~CLTS MCO/SE~~] CoLTS MCO/SE shall remain responsible for processing and paying claims for services delivered through the contract period, but submitted after the [~~CLTS MCO's/SE's~~] CoLTS MCO's/SE's contract has ended.

(1) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall be required to inform service 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 service 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 [~~CLTS MCO/SE~~] CoLTS MCO/SE shall allow six months to process claims for services provided prior to the contract termination date.

(3) The [~~CLTS MCO/SE~~] CoLTS MCO/SE shall continue to meet timeframes established for processing all claims.

[8.307.16.9 NMAC - N, 8-1-08; A, 9-1-09]

NEW MEXICO MASSAGE THERAPY BOARD

This is an amendment to 16.7.1 NMAC, Section 7, effective September 4, 2009

16.7.1.7 DEFINITIONS:

[~~A. "Board"~~ ~~means the New Mexico board of massage therapy, hereinafter referred to as the board.~~

~~B. "Class hour"~~ ~~or~~ **~~"contact hour"~~** ~~means no less than fifty (50) minutes of any one-clock hour during which the student/massage therapist participates in a learning activity in the physical presence and under the tutelage of an instructor.~~

~~C. "Clinical practicum"~~ ~~means that a student is providing hands-on massage therapy to members of the public under the supervision of a registered massage therapy instructor. That instructor must be physically present on the premises for advice and assistance. The student must be enrolled at a registered massage therapy school or being trained by a registered massage therapy instructor. Clinical practicum does not include classroom practice.~~

~~D. "Compensation"~~ ~~means a gain, whether monetary, trade or barter, for massage therapy services.~~

~~E. "Massage therapy"~~ ~~means the assessment and treatment of soft tissues and their dysfunctions for therapeutic purposes primarily for comfort and relief of pain. It is a health care service that includes gliding, kneading, percussion, compression, vibration, friction, nerve strokes, stretching the tissue and exercising the range of motion, and may include the use of oils, salt glows, hot or cold packs or hydrotherapy. Synonymous terms for massage therapy include massage, therapeutic massage, body massage, myomassage, bodywork, body rub or any derivation of those terms. Massage therapy is the deformation of soft tissues from more than one anatomical point by manual or mechanical means to accomplish homeostasis and/or pain relief in the tissues being deformed, as defined in the Massage Therapy Practice Act, NMSA 1978, Section 61-12C-3.E.~~

~~F. "Treatment of soft tissues"~~ ~~is the repetitive deformation of soft tissues from more than one anatomical point by manual or mechanical means to accomplish homeostasis and/or pain relief in the tissues being deformed.~~

~~G. "Soft tissue"~~ ~~includes skin, adipose, muscle and myofascial tissues.~~

~~H. "Manual"~~ ~~means by use of hands or body.~~

~~I. "Mechanical"~~ ~~means any tool or device that mimics or enhances the actions possible by the hands.~~

~~J. "Deformation"~~ ~~specifically prohibits the use of high velocity thrust techniques used in joint manipulations.~~

~~K. "Massage Therapy Practice Act"~~ ~~refers to NMSA 1978, Sections 61-12C-1 et seq. (as amended through 1999).~~

~~L. "Related hands-on modalities"~~ ~~means manual therapies, not directly defined as massage therapy.~~

~~M. "Semester hour" or "credit hour"~~ ~~means one (1) semester credit hour, which is equivalent to fifteen (15) class or contact hours.~~

~~N. "Uniform Licensing Act"~~ ~~refers to NMSA 1978, Sections 61-1-1 et seq. (as amended through 2003).~~]

A. "Academic hour" means continuing education taken in an academic setting that is equivalent to fifteen (15) class or contact hours.

B. "Active status" means a license that is current and authorized the licensee or registrant to perform the practice or service authorized by the license or registration.

C. "Board" means the

New Mexico board of massage therapy, hereinafter referred to as the board.

D. "Board administrator" or "administrator" means the staff person assigned certain express or implied executive and administrative function of the board as defined by board regulations or as required to carry out the provisions of the act.

E. "Class hour" or **"contact hour"** means no less than fifty (50) minutes of any one-clock hour during which the student/massage therapist participates in a learning activity in the physical presence and under the tutelage of an instructor.

F. "Client" means a recipient of "professional services" or a massage therapy student. In the case of individuals not able to give legal consent their legal guardian shall be the client for decision making purposes.

G. "Clinical practicum" means that a student is providing hands-on massage therapy to members of the public under the supervision of a current registered massage therapy instructor. That instructor must be physically present on the premises for advice and assistance. The student must be enrolled at a registered massage therapy school or being trained by a registered massage therapy instructor. Clinical practicum does not include classroom practice.

H. "Compensation" means a gain, whether monetary, trade or barter, for massage therapy services.

I. "Complainant" means the complaining party of a complaint filed against a licensee(s), registrant(s), or applicant(s) for licensure or registration.

J. "Complaint" means a sworn written complaint.

K. "Confidential information" means personally identifiable information revealed by a client.

L. "Deformation" specifically prohibits the use of high velocity thrust techniques used in joint manipulation.

M. "Examining agency" means the national certification board for therapeutic massage and bodywork (NCBTMB) or the federation of state massage therapy boards (FSMTB).

N. "Expired status" means a license that has not been reactivated from inactive status and can no longer be reactivated.

O. "Grace period" refers to the sixty (60) day period following the renewal date when a massage therapist, licensee, massage therapy instructor or massage school registrant may renew a license or registration (that was not renewed timely) with a penalty fee. A licensee or registrant may still practice or provide the services authorized by the license or registration during those sixty (60) days.

P. "Grace period status" refers to the license or registration that has not been renewed by the renewal date assigned to it, but has not yet been placed on inactive status.

Q. "Inactive status" occurs when a massage therapist's license or massage therapist instructor's registration is not renewed by the end of the grace period allowed for in the licensee's or registrant's renewal cycle. A license or registration can also be placed on inactive status for a period of two (2) years. If the inactive license or registration is not reactivated within those two (2) years, it automatically expires, lapses and becomes null and void.

R. "Inactive status period" refers to a period not to exceed two (2) years and only applies to massage therapists and massage therapy instructors.

S. "Jurisprudence" means an examination covering the Massage Therapy Practice Act and the board's rules and regulations, 16.7 NMAC.

T. "Lapsed status" means the license or registration is null and void, is no longer valid and cannot be reactivated.

U. "Licensee" means a person whose professional conduct is subject to regulation by the board.

V. "Manual" means by use of hands or body.

W. "Massage therapist" means a person licensed to practice massage therapy pursuant to the New Mexico Massage Therapy Practice Act, NMSA 1978, Section 61-12C-3E.

X. "Massage therapy" means the assessment and treatment of soft tissues and their dysfunctions for therapeutic purposes primarily for comfort and relief of pain. It is a health care service that includes gliding, kneading, percussion, compression, vibration, friction, nerve strokes, stretching the tissue and exercising the range of motion, and may include the use of oils, salt glows, hot or cold packs or hydrotherapy. Synonymous terms for massage therapy include massage, therapeutic massage, body massage, myomassage, bodywork, body rub or any derivation of those terms. Massage therapy is the deformation of soft tissues from more than one anatomical point by manual or mechanical means to accomplish homeostasis or pain relief in the tissues being deformed, as defined in the Massage Therapy Practice Act, NMSA 1978, Section 61-12C-3.E.

Y. "Massage therapy instructor" refers to a school based instructor or an independent instructor who is registered by the board.

Z. "Massage Therapy Practice Act" refers to NMSA 1978, Sections 61-12C-1 et seq. (as amended through 1999).

AA. "Massage therapy school" means a facility providing an educational program in massage therapy that is registered by the board.

BB. "MBLEX" means the massage and bodywork licensing examination.

CC. "Mechanical" means any tool or device that mimics or enhances the actions possible by the hands.

DD. "National certification examination" means the national certification examination for therapeutic massage and bodywork (NCETMB) or the national certification examination for therapeutic massage (NCETM).

EE. "Notice of contemplated action" means the administrative process used by the board for a licensee, registrant or applicant for licensure or registration to be afforded notice and an opportunity to be heard in a formal hearing before the board, before the board has authority to take any action which would result in denial, suspension, revocation, restriction, probation, monitoring, censuring, etc., of a license, registration, application or licensure or registration.

FF. "Null and void status" means the license or registration is no longer valid and cannot be reactivated.

GG. "Official examination results" mean official pass/fail reports that the applicant has made arrangements to be sent directly to the board by the national certification board for therapeutic massage and bodywork or the federation of state massage therapy boards.

HH. "Official transcripts" means those transcripts provided to the board office by the massage therapy school where the applicant received training.

II. "Permanent license" means a license issued once the applicant has met all the requirements for licensure as set forth in this regulation, but which must be kept updated by meeting the board's renewal and continuing education requirements, and which is subject to disciplinary action by the board for violations of the board's statute or regulations, up to an including revocation.

JJ. "Professional massage therapy experience" means lawful massage therapy services performed for compensation.

KK. "Professional relationship" means a business relationship between a licensee and a client for the purpose of the client obtaining the licensee's "professional services.

LL. "Professional services" means all actions of the licensee in the context of a "professional relationship" with a client.

MM. "Related hands-on modalities" means manual therapies, not directly defined as massage therapy.

NN. "Renew" means to begin again after an interval of time; to make

valid again for a further period.

OO. "Renewal date" means the deadline date upon which the license or registration must be made valid again for another period of time.

PP. "Respondent" means a licensee, registrant or applicant for licensure or registration who is governed under the Massage Therapy Practice Act, and who is the subject of a complaint.

QQ. "Semester hour" or "credit hour" means one (1) semester credit hour, which is equivalent to fifteen (15) class or contact hours.

RR. "Sexual conduct" includes, but is not limited to, sexual intercourse, indecent exposure, sexual assault, non-therapeutic ano-genital contact or any offer or agreement to engage in any such activities.

SS. "Soft tissue" includes skin, adipose, muscle and myofascial tissues.

TT. "Student" means an individual currently enrolled in or attending class(es) in a massage therapy program under the jurisdiction of the New Mexico state board of massage therapy.

UU. "Teaching assistant" means an individual who assists the registered instructor in class. Any instruction to students must be performed while under the direct supervision of the registered massage therapy instructor.

VV. "Temporary license" means a license issued one-time only for a maximum period of three (3) months to practice massage therapy while the application for permanent license is in process, and which may only be issued to applicants who have never sat for a licensing examination.

WW. "Treatment of soft tissues" is the repetitive deformation of soft tissues from more than one anatomical point by manual or mechanical means to accomplish homeostasis or pain relief in the tissues being deformed.

XX. "Uniform Licensing Act" refers to NMSA 1978, Sections 61-1-1 et seq. (as amended through 2003).

[2-16-92; 4-25-92; 12-16-92; 2-4-94; 7-28-96; 5-11-97; 7-30-99; 12-24-99; 16.7.1.7 NMAC - Rn & A, 16 NMAC 7.1.7, 06-28-01; A, 06-24-05; A, 09-04-09]

NEW MEXICO MASSAGE THERAPY BOARD

This is an amendment to 16.7.2 NMAC, Section 7, effective September 4, 2009.

16.7.2.7 DEFINITIONS:

[~~A. **"Licensee"** means a person whose professional conduct is subject to regulation by the board.~~

~~B. **"Client"** means a recipient of "professional services" or a massage therapy student. In the case of individuals not able to give legal consent their legal guardian shall be the client for decision making purposes.~~

~~C. **"Professional services"** means all actions of the licensee in the context of a "professional relationship" with a client.~~

~~D. **"Professional relationship"** means a business relationship between a licensee and a client for the purpose of the client obtaining the licensee's "professional services."~~

~~E. **"Confidential information"** means personally identifiable information revealed by a client to a licensee.~~

~~F. **"Sexual conduct"** includes, but is not limited to, sexual intercourse, indecent exposure, sexual assault, non-therapeutic ano-genital contact or any offer or agreement to engage in any such activities.~~] [RESERVED]

[1-11-96; 16.7.2.7 NMAC - Rn, 16 NMAC 7.2.7, 06-28-01; A, 09-04-09]

[Refer to 16.7.1.7 NMAC]

NEW MEXICO MASSAGE THERAPY BOARD

This is an amendment to 16.7.3 NMAC, Sections 7 and 8, effective September 4, 2009.

16.7.3.7 DEFINITIONS:

[~~**"Inactive status"** occurs when a massage therapist's license or massage therapist instructor's registration is not renewed by the end of the grace period allowed for in the licensee's or registrant's renewal cycle. A license or registration can also be placed on inactive status for a period of two years. If the inactive license or registration is not reactivated within those two years, it automatically expires, lapses and becomes null and void.~~] [RESERVED]

[7-28-96; 16.7.3.7 NMAC - Rn, 16 NMAC 7.3.7, 06-28-01; A, 06-24-05; A, 09-04-09]

[Refer to 16.7.1.7 NMAC]

16.7.3.8 FEE SCHEDULE:

A. Massage therapist:

(1) Application: $75.00

(2) Initial license: Pro-rated $5.00/mo.

(3) Biennial renewal: $125.00

(4) Late renewal penalty: $75.00

(5) Renewal during the grace period: $125.00 plus late renewal penalty fee

(6) Reactivation from inactive status: $125.00 plus late renewal penalty fee

(7) Review fee for "other" elective courses as provided in 16.7.4.14 NMAC): $50.00

B. Massage therapy instructor:

(1) Registration: $50.00

(2) Biennial renewal - school based: $25.00

(3) Biennial renewal - independent: $50.00

(4) Late renewal penalty: $75.00

(5) Renewal during the grace period: $50.00 plus late renewal penalty

(6) Reactivation from inactive status: $50.00 plus late renewal penalty fee

C. Massage therapy school:

(1) Registration: $50.00

(2) Annual renewal: $50.00

(3) Late renewal penalty: $75.00

(4) Application review: $400.00

(5) Curriculum change review: $50.00

D. Administrative fees:

(1) Temporary license: $25.00

(2) Visiting massage therapy instructor: $50.00

(3) ~~[Lists]~~ Paper lists: $50.00

(4) Labels: $75.00

(5) Electronic list: $125.00

[~~**(5)**~~] **(6)** Other administrative fees (at the discretion of the board [~~and/or~~] or board administrator) not to exceed $500.00

E. ALL FEES COLLECTED BY THE BOARD ARE NON-REFUNDABLE.

[2-16-92 … 7-28-96; 6-1-99; 12-24-99; 16.7.3.8 NMAC - Rn & A, 16 NMAC 7.3.8, 06-28-01; A, 06-24-05; A, 09-04-09]

NEW MEXICO MASSAGE THERAPY BOARD

This is an amendment to 16.7.4 NMAC, Sections 7, 8, 9, 10, 12, 13, 17 and 18, effective September 4, 2009.

16.7.4.7 DEFINITIONS:

[~~**A. "Official transcripts"** means those transcripts provided to the board office by the massage therapy school where the applicant received training.~~

~~**B. "Clinical practicum"** means that a student is providing hands-on massage therapy to members of the public under the supervision of a registered massage therapy instructor. That instructor must be physically present on the premises for advice and assistance. The student must be enrolled at a registered massage therapy school or being trained by a registered massage therapy instructor. Clinical practicum does not include classroom practice.~~

~~**C. "Examining agency"** means the national certification board for therapeutic massage and bodywork (NCBTMB).~~

~~**D. "Jurisprudence"** means the statutes and rules of the state pertaining to the practice of massage therapy.~~

~~**E. "Massage therapy"** means the assessment and treatment of soft tissues and their dysfunctions for therapeutic purposes primarily for comfort and relief of pain. It is a health care service that includes gliding, kneading, percussion, compression, vibration, friction, nerve strokes, stretching the tissue and exercising the range of motion, and may include the use of oils, salt glows, hot or cold packs or hydrotherapy. Synonymous terms for massage therapy include massage, therapeutic massage, body massage, myomassage, bodywork, body rub or any derivation of those terms. Massage therapy is the deformation of soft tissues from more than one anatomical point by manual or mechanical means to accomplish homeostasis and/or pain relief in the tissues being deformed, as defined in the Massage Therapy Practice Act, NMSA 1978, Section 61-12C-3.E.~~

~~**F. "Massage therapist"** means a person licensed to practice massage therapy pursuant to the New Mexico Massage Therapy Practice Act, Sections 61-12C-1 through 61-12C-28 NMSA 1978.~~

~~**G. "National certification examination or NCE"** means the national certification examination for therapeutic massage and bodywork (NCETMB)~~

~~**H. "Official examination results"** means official pass/fail reports that the applicant has made arrangements to be sent directly to the board by the national examination agency.~~

~~**I. "Permanent license"** means a license issued once the applicant has met all the requirements for licensure as set forth in this regulation, but which must be kept updated by meeting the board's renewal and continuing education requirements, and which is subject to disciplinary action by the board for violations of the board's statute or regulations, up to an including revocation.~~

~~**J. "Temporary license"** means a license issued one-time only for a maximum period of three (3) months to practice massage therapy while the application for permanent license is in process, and which may only be issued to applicants who have never sat for the national examination (NCE).~~ [RESERVED]
[16.7.4.7 NMAC - Rp, 16.7.4.7 NMAC, 07-28-05; A, 09-04-09]
[Refer to 16.7.1.7 NMAC]

16.7.4.8 LICENSE OR REGISTRATION REQUIRED:

A. Massage therapists: A person must be licensed by the board in order to legally provide or offer to provide massage therapy services for compensation, as defined in [~~16.7.4.7~~] **16.7.1.7** NMAC; or to use the title or represent him/herself to be a massage therapist; or to use any other title, abbreviations, letters, figures, signs or devices that indicate the person is a massage therapist.

B. Massage therapy instructors: A person shall be registered by the board, as set forth in [~~16.7.5~~] **16.7.6** NMAC, in order to legally provide or offer to provide massage therapy training as a massage therapy instructor.

C. Massage therapy schools: Massage therapy schools must be registered by the board, as set forth in [~~16.7.6~~] **16.7.5** NMAC, before they can legally operate and offer education, instruction or training in massage therapy.
[16.7.4.8 NMAC - N, 07-28-05; A, 09-04-09]

16.7.4.9 LICENSURE EXEMPTIONS: The following are exempted from licensure by the board pursuant to Section 61-12C-5.1 of the Massage Therapy Practice Act.

A. Other professionals licensed in or regulated by another New Mexico licensing board or agency rendering services within the scope of their authorizing law or regulation, provided they do not represent themselves as massage therapists.

B. Massage therapy students who are rendering massage therapy services within the course of study of a registered massage therapy school or under the supervision of a registered massage therapy instructor.

C. Massage therapy instructors visiting New Mexico who have met the requirements set forth in 16.7.6.11 NMAC.

D. Sobadores; Hispanic traditional healers; Native American healers; reflexologists whose [~~practice is~~] practices are limited to hands, feet and ears; [~~or other healers~~] practitioners of polarity, Trager approach, Feldenkrais method, craniosacral therapy, Rolfing structural integration, reiki, ortho-bionomy or ch'i gung; or practitioners of healing modalities not listed in this subsection who do not manipulate the soft tissues for therapeutic purposes from practicing those skills. However, if any of these persons applies for and is granted a license pursuant to the Massage Therapy Practice Act, that person shall comply with all licensure requirements and be subject to the provisions of the boards' statute and regulations.
[16.7.4.9 NMAC - N, 07-28-05; A, 09-04-09]

16.7.4.10 GENERAL PROVISIONS FOR LICENSURE:

A. Age: The applicant must be eighteen (18) years of age or older on the date the application is submitted.

B. Pre-requisite education to massage therapy training: The applicant must have completed high school or its equivalent.

C. Photograph: The applicant must provide a 2"x 2" head and shoulders frontal view photograph taken of the applicant within the six-months prior to making application for licensure.

D. Application fee: The applicant must pay the required application-processing fee as set forth in Subsection D of 16.7.3.8 NMAC of the board's regulations.

E. Board-approved application form: The applicant must provide a completed, [~~notarized, and~~] legible board-approved application **[**~~for licensure~~**]** form that must either be typed or printed in black ink, along with any other [~~application~~] documents required in the board's application process.

(1) Incomplete application for licensure forms will be returned to the applicant for completion.

(2) Faxed application for licensure forms will not be accepted.

F. First aid and CPR: The applicant must have completed four course hours of cardiopulmonary resuscitation (CPR) and four course hours of first aid and must provide proof, with the application, of current certification in basic life support accepted by the American heart association or the American red cross.
[16.7.4.10 NMAC - Rp, 16.7.4.8 NMAC, 07-28-05; A, 09-04-09]

16.7.4.12 MINIMUM HOURS OF MASSAGE THERAPY TRAINING: The applicant must have completed at least a six hundred fifty (650) hour **program** in massage therapy training. The massage therapy training must meet the following minimum curriculum requirements:

A. [~~125~~] 165 hours *minimum* of anatomy and physiology, to include:

(1) physiology;

(2) anatomy;

(3) kinesiology; and

(4) forty (40) hours *minimum* of pathology.

B. 150 hours *minimum* of training in massage therapy as defined in [~~16.7.4.7~~] **16.7.1.7** NMAC.

(1) The massage therapy training shall include contraindications of massage therapy.

(2) A minimum of 100 hours of [~~massage therapy~~] hands on training must be completed before the student is allowed to begin a clinical practicum as defined in [~~16.7.4.7~~] **16.7.1.7** NMAC.

C. [~~50~~] 75 hours *minimum* of general instruction to include.

(1) business;

(2) hydrotherapy;

(3) [~~six (6) hour~~] thirty (30) hours *minimum* of professional ethics;

(4) four hours of first aid; and

(5) four hours of cardiopulmonary

resuscitation.

D. Electives may include:

(1) additional massage therapy;

(2) related hands-on modalities;

(3) additional anatomy and physiology;

(4) clinical practicum (not to exceed 150 hours);

(5) counseling;

(6) herbology;

(7) homeopathy;

(8) nutrition;

(9) breathing and stretching techniques;

(10) theory; and

(11) other courses with prior board approval. See 16.7.4.14 NMAC for instructions.

E. The total number of hours in the massage therapy program is a minimum of six hundred fifty (650) hours.

F. If an applicant is missing a core curriculum course or is missing a small portion of the core curriculum to complete the 650-hour requirement, the applicant may obtain the training course(s) from a New Mexico registered independent instructor, or from a New Mexico registered school, or from another massage therapy school that meets the requirements in 16.7.4.13 NMAC.

~~**[G. Effective October 31, 2006 - change in number of required hours:** The minimum number of hours required in curriculum programs listed below in Paragraphs (1), (2), and (3) of Subsection G of 16.7.4.12 NMAC will increase as follows effective October 31, 2006. The requirements for all other curriculum programs in Subsections A, B, C, and D of 16.7.4.12 NMAC will remain the same.~~

~~**(1) 165** hours minimum in anatomy and physiology;~~

~~**(2) 75** hours minimum in general instruction; and~~

~~**(3) thirty (30) hours** minimum in professional ethics.~~]

[16.7.4.12 NMAC - N, 07-28-05; A, 06-08-06; A, 09-04-09]

16.7.4.13 FORM "A" FROM MASSAGE SCHOOL REQUIREMENT:

A. The following circumstances require that the applicant's massage school(s) submit a completed "form A for massage school" to the board office along with an official transcript and proof that the massage therapy school(s) is/was approved to operate as a private post-secondary educational institution or its equivalent at the time the applicant attended the school(s):

(1) if the applicant attended a massage school that is located out-of-state; or

(2) if the applicant has attended more than one massage therapy school whether in-state or out-of-state**; or**

(3) if the applicant graduated from a massage therapy school more than two (2) years ago.

B. The "form A for massage school" contains four sections corresponding to Subsections A, B, C, and D of 16.7.4.12 NMAC, and each section must be completed correctly to prevent delays in the applicant's licensure process.

(1) An hourly breakdown *must* be provided for *each* course/category/subject listed that the school provided in the curriculum that the applicant completed. If a subject is taught within another subject, the school should provide a written explanation on school letterhead and attached to the form "A".

(2) If there are no hours specified next to a course/category/subject, it will be an indication to the board that the course/category/subject was NOT part of the school's curriculum.

[16.7.4.13 NMAC - N, 07-28-05; A, 09-04-09]

16.7.4.17 SPECIFIC PROVISION FOR PERMANENT LICENSURE: The applicant must meet all the requirements set forth in Sections 16.7.4.10 through 16.7.4.15 NMAC, in addition to the following requirements:

A. Jurisprudence examination: The applicant for permanent licensure must successfully pass the board's jurisprudence examination as set forth in 16.7.10.8 NMAC.

B. National certification examination: The applicant must successfully pass the national certification examination for therapeutic massage and bodywork (NCETMB), or the national examination for therapeutic massage (NCETM) as provided in 16.7.10.9 NMAC, and must make arrangements for the national examining agency to send official examination results, as defined in 16.7.4.7 NMAC, directly to the board.

C. MBLEx: The applicant must successfully pass the massage and bodywork licensing examination, and must make arrangements for the examining agency to send official examination results directly to the board.

[C.] D. Licensure fee: Upon written notification, sent by the board by certified mail return receipt requested, that the applicant has met all other requirements for licensure, the applicant must submit the initial license fee as stated in the notification based on the fee structure set forth in Subsection A of 16.7.3.8 NMAC.

(1) The initial licensure fee must be paid in full before the permanent license will be issued.

(2) If the applicant fails to pay the initial license fee within thirty (30) days of receipt of the notification of approval, the application will be deemed withdrawn and subject to the provisions in 16.7.4.19 NMAC.

[16.7.4.17 NMAC - N, 07-28-05; A, 09-04-09]

16.7.4.18 REQUIREMENTS FOR LICENSURE BY CREDENTIALS:

A. In addition to the requirements in Sections 16.7.4.10 through 16.7.4.15 and 16.7.4.17 NMAC, the applicant for licensure by credentials must provide verification of a current, valid massage therapy license in another state/territory of the United States, the District of Columbia or foreign nation.

(1) Verification of licensure or registration as a massage therapist must be sent directly to the board by the other licensing jurisdiction.

(2) The license to practice massage therapy must be in good standing. [~~Any prior disciplinary actions by any other licensing jurisdictions related to health, safety and welfare or other civil or criminal issues that may be reasons for disciplinary action by the board will be evaluated on a case-by-case basis and may be basis for issuance of a conditional or provisional license or other disciplinary action by the board up to and including denial of licensure.~~] A prior disciplinary action by another licensing jurisdiction, related to health, safety and welfare, or any other civil or criminal issues will be evaluated by the board on a case by case basis. The review may lead to the issuance of a conditional or provisional license or to other disciplinary action up to and including denial of licensure.

B. The applicant must have met educational and examination requirements in the other jurisdiction equal to or exceeding New Mexico's educational and examination requirements.

[16.7.4.18 NMAC - Rp, 16.7.4.10 NMAC, 07-28-05; A, 09-04-09]

NEW MEXICO MASSAGE THERAPY BOARD

This is an amendment to 16.7.5 NMAC, Sections 7, 8 and 9, effective September 4, 2009

16.7.5.7 DEFINITIONS:

~~**[A. "Clinical practicum"** means that a student is providing hands-on massage therapy to members of the public under the supervision of a registered massage therapy instructor. That instructor must be physically present on the premises for advice and assistance. The student must be enrolled at a registered massage therapy school or being trained by a registered massage therapy instructor. Clinical practicum does not include classroom practice.~~

~~**B. "Related hands-on modalities"** means manual therapies not directly defined as massage therapy.~~

~~**C. "Massage therapy"** means the assessment and treatment of soft tissues and their dysfunctions for therapeutic purposes primarily for comfort and relief of pain. It is a health care service that includes gliding, kneading, percussion, compression, vibration, friction, nerve strokes, stretching the tissue and exercising the range of motion, and may include the use of oils, salt glows, hot or cold packs or hydrotherapy. Synonymous terms for massage therapy include massage, therapeutic massage, body massage, myomassage, bodywork, body rub or any derivation of those terms. Massage therapy is the deformation of soft tissues from more than one anatomical point by manual or mechanical means to accomplish homeostasis and/or pain relief in the tissues being deformed, as defined in the Massage Therapy Practice Act, NMSA 1978, Section 61-12C-3.E.]~~ [RESERVED]

[12-24-99; 16.7.5.7 NMAC - Rn, 16 NMAC 7.5.7, 06-28-01; A, 07-28-05; A, 09-04-09] [Refer to 16.7.1.7 NMAC]

16.7.5.8 REQUIREMENTS FOR REGISTRATION: At the time of application the applicant will provide the following information to the board.

A. A completed, [~~notarized, and~~] legible application for licensure [~~form~~], which must either be typed or printed in black ink. Incomplete applications will not be accepted and will be returned to the applicant for completion.

[~~**(1)** Incomplete application forms will be returned to the applicant for completion.~~

~~**(2)** Faxed applications and/or supporting documentation will not be accepted.~~]

B. **[**~~A curriculum that must provide a massage therapy training program of a minimum of 650 hours. The curriculum will include:~~] A 650 hour curriculum that must meet the following minimum requirements,

(1) [~~**125**~~**] 165 hours *minimum* of anatomy and physiology,** to include:

(a) physiology;

(b) anatomy;

(c) kinesiology; and

(d) 40 hours *minimum* of pathology.

(2) 150 hours *minimum* of massage therapy as defined in [~~16.7.5.7 NMAC~~] 16.7.1.7 NMAC.

(a) Shall include contraindications of massage therapy.

(b) A *minimum* of 100 hours of [~~massage therapy education~~] hands on training must be completed before a student may begin clinical practicum, as defined in Subsection [~~A of 16.7.5.7 NMAC~~] G of 16.7.1.7 NMAC.

(3) [~~**50**~~**] 75 hours *minimum* of general instruction**, to include:

(a) business;

(b) hydrotherapy;

(c) first aid - 4 hours;

(d) cardiopulmonary resuscitation - 4 hours;

(e) [~~six (6)~~] thirty (30) hours *minimum* of professional ethics[~~;~~

~~**(f)** proof of current certification in basic life support accepted by the American heart association or the American red cross~~].

(4) Electives may include:

(a) additional massage therapy;

(b) related hands-on modalities;

(c) additional anatomy and physiology;

(d) clinical practicum (not to exceed 150 hours);

(e) counseling;

(f) herbology;

(g) homeopathy;

(h) nutrition;

(i) breathing and stretching techniques;

(j) theory;

(k) other, with prior board approval.

C. Policies and procedures for board review, including but not limited to:

(1) enrollment and financial;

(2) cancellation/withdrawal and refund;

(3) grading method;

(4) attendance and make up;

(5) students conduct and discipline:

(6) dress code;

(7) hygiene protocol;

(8) draping procedures;

(9) evaluation forms;

(10) curriculum;

(11) advertising catalog;

(12) list of text books for all courses; and

(13) qualifications of instructors not registered with the board as massage therapy instructors.

D. Massage therapy school registration fee in accordance with Subsection C of 16.7.3.8 NMAC.

~~**[E. Effective October 31, 2006 - change in number of required hours:** The minimum number of hours required in curriculum programs listed below in Paragraphs (1), (2), and (3) of Subsection E of 16.7.5.8 NMAC will increase as follows effective October 21, 2006. The requirements for all other curriculum programs in Subsections A, B, and C of 16.7.5.8 NMAC will remain the same.~~

~~**(1) 165** hours minimum in anatomy and physiology;~~

~~**(2) 75** hours minimum in general instruction; and~~

~~**(3) thirty (30) hours** minimum in professional ethics.~~]

[12-24-99; 16.7.5.8 NMAC - Rn & A, 16 NMAC 7.5.8, 06-28-01; A, 07-28-05; A, 06-08-06; A, 09-04-09]

16.7.5.9 INSPECTIONS OF SCHOOLS: The massage therapy school will be inspected by a board appointed inspector upon registration and thereafter as needed. Findings of the inspector will be reported to the board as part of the approval process. If an inspection reveals that a school is not in compliance with the board's laws or rules, the school will have thirty (30) days to become compliant; at which time, the school will be re-inspected. If the school fails a second inspection, the board may take action against the school for non-compliance.

A. Provisional registration: A provisional registration will be given to a new school until the school is operating and available for inspection.

B. Term of provisional registration: The provisional registration will be valid no longer than one year from the date of issuance.

C. Inspection criteria: The inspector will observe and report on the following:

(1) cleanliness of premises and compliance with board policy;

(2) state school registrations and instructor registrations and a file of their qualifications;

(3) local business license posted;

(4) posted complaint policy with board address and phone number available;

(5) student clinic log;

(6) student attendance log;

(7) student files; and

(8) equipment and teaching aids.

[12-24-99; 16.7.5.9 NMAC - Rn, 16 NMAC 7.5.9, 06-28-01; A, 07-28-05; A, 09-04-09]

NEW MEXICO MASSAGE THERAPY BOARD

This is an amendment to 16.7.6 NMAC, Section 7, effective September 4, 2009.

16.7.6.7 DEFINITIONS:

[~~**A. "Professional massage therapy experience"** means lawful massage therapy services performed for compensation.~~

~~**B. "Compensation"** means gain, either monetary or trade or bartering for massage therapy services.~~

~~**C. "Class hour"** or **"contact hour"** means no less than fifty (50) minutes of any one-clock hour during which the student/massage therapist participates in a learning activity in the physical presence and under the tutelage of an instructor.~~

~~**D. "Massage therapy"** means the assessment and treatment of soft tissues and their dysfunctions for therapeutic purposes primarily for comfort and relief of pain. It is a health care service that includes gliding, kneading, percussion, compression, vibration, friction, nerve strokes, stretching the tissue and exercising the range of motion, and may include the use of oils, salt glows, hot or cold packs or hydrotherapy. Synonymous terms for massage therapy include massage, therapeutic massage, body massage, myomassage, bodywork, body rub or any derivation of those terms. Massage therapy is the deformation of soft tissues from more than one anatomical point by manual or mechanical means to accomplish homeostasis and/or pain relief in the tissues being deformed, as defined in the Massage Therapy Practice Act, NMSA 1978, Section 61-12C-3.E.~~

~~**E. "Teaching assistant"** means an individual who assists the registered instructor in class. Any instruction to students must be performed while under the direct supervision of the registered massage therapy instructor.~~] [RESERVED]
[12-24-99; 16.7.6.7 NMAC - Rn, 16 NMAC 7.6.7, 06-28-01; A, 06-24-05; A, 09-04-09]
[Refer to 16.7.1.7 NMAC]

NEW MEXICO MASSAGE THERAPY BOARD

This is an amendment to 16.7.7 NMAC, Sections 1, 7 and 8, effective September 4, 2009.

16.7.7.1 ISSUING AGENCY: Regulation and Licensing Department, Board of Massage Therapy [~~, P.O. Box 25101, Santa Fe, New Mexico 87504, (505) 476-7090.~~]
[7-28-96; 16.7.7.1 NMAC - Rn, 16 NMAC 7.7.1, 06-28-01; A, 09-04-09]
[P. O. Box 25101 Santa Fe, New Mexico 87504]

16.7.7.7 DEFINITIONS:

[~~A. "**Student**" means an individual currently enrolled in and/or attending class(es) at a massage therapy program under the jurisdiction of the New Mexico state board of massage therapy.~~

~~[B. [Reserved]~~] [RESERVED]
[7-28-96; 5-11-97; 16.7.7.7 NMAC - Rn, 16 NMAC 7.7.7, 06-28-01; A, 09-04-09]
[Refer to 16.7.1.7 NMAC]

16.7.7.8 GENERAL PROVISIONS:

A. Students not yet licensed may not charge for massage therapy services.

(1) Students may only accept voluntary unsolicited tips, gratuities and donations while practicing massage therapy under school endorsed functions, under the supervision of a registered massage therapy instructor.

(2) Students may not suggest either verbally or in writing, amounts of tips, gratuities or donations.

B. Students may distribute identification cards which must include the school's name, address, and phone number; the student's name, and the word "student".

C. **Student complaints:**

(1) Complaints concerning the registered massage therapy school, instructor(s), [~~and/or~~] or other student(s) should first be addressed through the registered massage therapy school's complaint policy.

(2) If the school does not resolve the complaint adequately, or in extreme circumstances, a complaint may be brought before the board in accordance with 16.7.14.8 NMAC.

D. Students will comply with 16.7.2 NMAC, Professional Conduct.
[7-28-96; 16.7.7.8 NMAC - Rn, 16 NMAC 7.7.8, 06-28-01; A, 09-04-09]

NEW MEXICO MASSAGE THERAPY BOARD

This is an amendment to 16.7.10 NMAC, Sections 7, 9 and 10, effective September 4, 2009.

16.7.10.7 DEFINITIONS:

[~~**A.** "**Jurisprudence**" means an examination covering the Massage Therapy Practice Act and the board's rules and regulations, 16.7 NMAC.~~

~~**B. "National certification examination"** means the national certification examination for therapeutic massage and bodywork (NCETMB) or the national certification examination for therapeutic massage (NCETM).~~

~~**C. "Examining agency"** means the national certification board for therapeutic massage and bodywork (NCBTMB).~~

~~**D.** "**Official examination results"** means official pass/fail reports the examining agency sends directly to the board pursuant to the applicant's instructions.~~] [RESERVED]
[4-25-92 … 7-28-96; 16.7.10.7 NMAC - Rn, 16 NMAC 7.10.7, 06-28-01; A, 09-30-05; A, 09-04-09]
[Refer to 16.7.1.7 NMAC]

16.7.10.9 [~~NATIONAL CERTIFICATION~~] LICENSING EXAMINATION:

A. Applicants for massage therapy licensure must successfully pass either the national certification examination for therapeutic massage and bodywork (NCETMB)**,** [~~**or**~~] the national certification examination for therapeutic massage (NCETM) administered by the national certification board for therapeutic massage and bodywork (NCBTMB), or the massage and bodywork licensing examination (MBLEx) administered by the federation of state massage therapy boards.

B. The candidate must apply to take the [~~national certification~~] NCETMB, NCETM or the MBLEx examination and meet the examining agency's requirements.

C. The applicant must ensure that the examining agency sends the official examination results directly to the board office.
[10-9-92 … 7-28-96; 16.7.10.9 NMAC - Rn, 16 NMAC 7.10.9, 06-28-01; A, 09-30-05; A, 09-04-09]

16.7.10.10 PROCEDURES TO RETAKE [~~THE NATIONAL~~] A LICENSING EXAMINATION: Applicants who fail to pass the [~~national~~] NCETMB, NCETM or the MBLEx examination must apply directly to the examining agency to retake the examination.
[4-25-92 … 7-28-96; 16.7.10.10 NMAC - Rn & A, 16 NMAC 7.10.10, 06-28-01; A, 09-30-05; A, 09-04-09]

NEW MEXICO MASSAGE THERAPY BOARD

This is an amendment to 16.7.11 NMAC, Sections 7, 9 and 10, effective September 4, 2009.

16.7.11.7 DEFINITIONS:

[~~A. **"Class hour"** or **"contact hour"** means no less than fifty (50) minutes of any one-clock hour during which the student/massage therapist participates in a learning activity in the physical presence and under the tutelage of an instructor.~~

~~B. **"Academic hour"** means continuing education taken in an academic setting that is equivalent to fifteen (15) class or contact hours."~~] [RESERVED]
[5-30-96; 16.7.11.7 NMAC - Rn, 16 NMAC 7.11.7, 06-28-01; A, 06-24-05; A, 09-30-05; A, 09-04-09]

16.7.11.9 CONTINUING EDUCATION PROGRAMS FOR MASSAGE THERAPISTS: [~~As an example, the board will accept the following types of continuing education offerings as long as they contribute directly to the enhancement of the licensees' massage therapy practice and education:~~

~~A. Courses, seminars, workshops and classes in areas related to~~

~~the practice of massage therapy such as: massage, bodywork, allied health care, psychology, anatomy and physiology, business, insurance, movement therapy, stress management, yoga, CPR, and advanced first aid.;~~

~~B. Courses of study offered by registered massage therapy schools or massage therapy instructors or by any NCBTMB category A or B provider;~~

~~C. The following methods for accruing continuing education may also be applied.~~

~~(1) Teaching a non-massage therapy qualifying class, course, seminar or workshop.~~

~~(2) Publishing an article in the field relating to massage therapy. No more than twelve (12) hours shall be granted for publishing a professional article in a local or regional publication, and no more than twelve (12) hours shall be granted for publishing a professional article in a national journal~~

~~(3) Massage therapist in-service programs related to the practice of massage therapy.~~

~~(a) No more than four (4) hours shall be granted.~~

~~(b) A brief written presentation must be provided which demonstrates the relationship to massage therapy.~~

~~D. Ethics requirement: All massage therapists shall be required to complete a minimum of four (4) hours of ethics training as part of the 16-hour requirement for each renewal period. In addition to the other methods of accruing continuing education listed in Subsections A and B of this section (16.7.11.9 NMAC), the ethics course may also be obtained through one of the following methods~~

~~(1) correspondence courses, or~~

~~(2) attending an ethics course from any other health related field.~~]

A. The board will accept the following types of continuing education which contribute directly to the licensee's massage therapy practice:

(1) courses, seminars, workshops and classes in areas related to the practice of massage therapy such as: massage, bodywork, allied health care, psychology, anatomy, physiology, business, insurance, movement therapy, stress management, yoga, CPR, and first aid;

(2) courses of study offered by registered massage therapy schools; massage therapy instructors; massage, bodywork, or allied healthcare professional organizations, NCBTMB continuing education providers, and accredited colleges and universities;

(3) publishing an article relating to massage therapy in a local, regional, or national publication, no more than twelve (12) hours of continuing education credit shall be granted in any renewal period.

B. Ethics requirement: All massage therapists shall be required to complete a minimum of four (4) hours of ethics training as part of the 16-hour requirement for each renewal period. Ethics courses must be taken from individuals or institutions listed in 16.7.11.9 NMAC.

C. Technique courses must be hands on.

[10-3-93…5-30-96; 16.7.11.9 NMAC - Rn & A, 16 NMAC 7.11.9, 06-28-01; A, 06-24-05; A, 09-04-09]

16.7.11.10 CONTINUING EDUCATION PROGRAMS FOR MASSAGE THERAPY INSTRUCTORS:

[~~The board will accept for compliance any of the following, but not limited to, subjects that contribute directly to the enhancement of massage therapy instruction of the registrant.~~

~~A. Courses, seminars, workshops and classes in areas related to pedagogy such as: class presentation techniques, class materials preparations, communications skills, research, cultural diversity, and counseling.~~

~~B. Courses of study offered by registered massage therapy schools or massage therapy instructors or by any NCBTMB category A or B provider;~~

~~C. Publishing an article in the field relating to massage therapy. No more than twelve (12) hours may be granted for publishing a professional article in a local or regional publication and no more than twelve (12) hours in a national journal.~~]

The board will accept the following types of continuing education which contribute directly to the registrants' massage therapy practice and instructional skills:

A. courses, seminars, workshops and classes in areas related to pedagogy such as: class presentation techniques, class materials preparations, communications skills, research, cultural diversity, and counseling;

B. courses of study offered by registered massage therapy schools, NCBTMB providers, registered massage therapy instructors, massage, bodywork, or allied health care professional organizations; accredited colleges and universities; or

C. publishing an article relating to massage therapy in a local, regional, or national publication; no more than twelve (12) hours of continuing education credit shall be granted in any renewal period.

[16.7.11.10 NMAC - N, 06-28-01; A, 06-24-05; A, 09-04-09]

NEW MEXICO MASSAGE THERAPY BOARD

This is an amendment to 16.7.12 NMAC, Section 7, effective September 4, 2009

16.7.12.7 DEFINITIONS:

[~~**A. "Active status"** means a license that is current and authorizes the licensee or registrant to perform the practice or service authorized by the license or registration.~~

~~**B. "Renew"** means to begin again after an interval of time; to make valid again for a further period.~~

~~**C. "Renewal date"** means the deadline date upon which the license or registration must be made valid again for another period of time.~~

~~**D. "Grace period"** refers to the sixty (60) day period following the renewal date when a massage therapist licensee, massage therapy instructor or massage school registrant may renew a license or registration (that was not renewed timely) with a penalty fee. A licensee or registrant may still practice or provide the services authorized by the license or registration during those sixty (60) days.~~

~~**E. "Grace period status"** refers to the license or registration that has not been renewed by the renewal date assigned to it, but has not yet been placed on inactive status.~~

~~**F. "Inactive status"** occurs when a massage therapist's license or massage therapist instructor's registration is not renewed by the end of the grace period allowed in the licensee's or registrant's renewal cycle. If the inactive license or registration is not reactivated within two years, it automatically expires, lapses and becomes null and void.~~

~~**G. "Inactive status period"** refers to a period not to exceed two years and only applies to massage therapists and massage therapy instructors, NOT to massage therapy schools.~~

~~**H. "Expired status"** means a license that has not been reactivated from inactive status and can no longer be reactivated.~~

~~**I. "Null and void status"** means the license or registration is no longer valid and cannot be reactivated.~~

~~**J. "Lapsed status"** means the license or registration is null and void, is no longer valid and cannot be reactivated.~~

~~**K. "Massage therapist"** means a person licensed to practice in accordance with the Massage Therapy Practice Act.~~

~~**L. "Massage therapy instructor"** refers to a school-based instructor or to an independent instructor who is registered by the board.~~

~~**M. "Massage therapy school"** means a facility providing an educational program in massage therapy that is registered by the board.~~

~~**N. "Uniform Licensing Act"** refers to NMSA 1978, Sections 61-1-1 *et seq.* (as amended through 2003).~~]

[RESERVED]
[16.7.12.7 NMAC - N, 06-24-05; A, 09-30-05; A, 09-04-09]
[Refer to 16.7.1.7 NMAC]

NEW MEXICO MASSAGE THERAPY BOARD

This is an amendment to 16.7.14 NMAC, Sections 1, 7 and 9, effective September 4, 2009.

16.7.14.1 ISSUING AGENCY: Regulation and Licensing Department, Board of Massage Therapy~~[, P.O. Box 25101, Santa Fe, New Mexico 87504, (505) 476-7090.]~~
[7-28-96; 6-1-99; 16.7.14.1 NMAC - Rn, 16 NMAC 7.14.1, 06-28-01; A, 09-04-09]
[P. O. Box 25101 Santa Fe, New Mexico 87504]

16.7.14.7 DEFINITIONS:

~~[A. **"Complaint"** means a sworn written complaint.~~

~~B. **"Complainant"** means the complaining party of a complaint filed against a licensee(s), registrant(s), or applicant for licensure or registration, who is/are regulated under the Massage Therapy Practice Act.~~

~~C. **"Respondent"** means a licensees, registrant(s) or applicant for licensure or registration who is/are governed under the Massage Therapy Practice Act, who is/are the subject of a complaint.~~

~~D. **"Notice of contemplated action"** means the administrative process used by the board for a licensee, registrant or applicant for licensure or registration to be afforded notice and an opportunity to be heard in a formal hearing before the board, before the board has authority to take any action which would result in denial, suspension, revocation, restriction, probation, monitoring, censuring, etc., of a license, registration, application or licensure or registration.~~] [RESERVED]
[7-28-96; 16.7.14.7 NMAC - Rn, 16 NMAC 7.14.7, 06-28-01; A, 09-04-09]
[Refer to 16.7.1.7 NMAC]

16.7.14.9 PROCEDURES FOR RECEIPT OF A COMPLAINT:

A. The board's designee will maintain a written log of all complaints received which records at a minimum, the date the complaint was received, and name, addresses of the complainant(s) and respondent(s).

B. Upon receipt of a complaint the board's designee will:

(1) log in the date the complaint was received;

(2) determine whether the respondent is licensed, registered or an applicant for licensure or registration with the board;

(3) assign a complaint number and create an individual file; complaint numbering will begin with the last two digits of the year in which the complaint is filed, followed by the month, and will then continue sequentially (e.g., 96-01-001 first = compliant filed **~~on~~]** in January 1996);

(4) send the complainant written acknowledgment of receipt of the complaint;

(5) immediately forward the complaint to the complaint committee; the complaint committee chair will be responsible for convening the complaint committee to review the complaint(s).
[7-28-96; 6-1-99; 16.7.14.9 NMAC - Rn, 16 NMAC 7.14.9, 06-28-01; A, 09-04-09]

NEW MEXICO PUBLIC EDUCATION DEPARTMENT

TITLE 6 PRIMARY AND SECONDARY EDUCATION
CHAPTER 29 STANDARDS FOR EXCELLENCE
PART 5 ENGLISH LANGUAGE DEVELOPMENT

6.29.5.1 ISSUING AGENCY: Public Education Department, hereinafter the department.
[6.29.5.1 NMAC - N, 08-31-2009]

6.29.5.2 SCOPE: All public schools, state educational institutions and educational programs conducted in state institutions other than New Mexico military institute.
[6.29.5.2 NMAC - N, 08-31-2009]

6.29.5.3 STATUTORY AUTHORITY:

A. Section 22-2-2 NMSA 1978 grants the authority and responsibility for the assessment and evaluation of public schools, state-supported educational institutions and educational programs conducted in state institutions other than New Mexico military institute.

B. Section 22-2-2 NMSA 1978 directs the department to set graduation expectations and hold schools accountable. Section 22-2C-3 NMSA 1978 requires the department to adopt academic content and performance standards and to measure the performance of public schools in New Mexico.
[6.29.5.3 NMAC - N, 08-31-2009]

6.29.5.4 DURATION: Permanent.
[6.29.5.4 NMAC - N, 08-31-2009]

6.29.5.5 EFFECTIVE DATE: August 31, 2009, unless a later date is cited at the end of a section.
[6.29.5.5 NMAC - N, 08-31-2009]

6.29.5.6 OBJECTIVE: The New Mexico content standards for English language development (NMELD) provides a companion piece to the New Mexico content standards for English language arts (6.29.4 NMAC). This document shall guide second-language instruction for PreK-12 English language learner students. The English language learner population falls into three basic categories: students whose primary or home language (L1) is other than English including recent immigrants; students from heritage language groups needing enrichment and further development of academic English, some of whom maintain degrees of fluency in their heritage language; and any other students needing enrichment and further development of academic English. Because instruction must address the appropriate proficiency level of the individual student, which may vary greatly for any age, some consideration must be made for the student's maturity level.
[6.29.5.6 NMAC - N, 08-31-2009]

6.29.5.7 DEFINITIONS:

A. "Academic content standards" means statements that define the knowledge and skills students need to know and be able to demonstrate as proof of competency in the core content areas associated with schooling.

B. "Academic language" means the language used in academic content in formal schooling contexts, including specialized or technical language and discourse related to each content area.

C. "Discourse" means extended, connected language that may include explanations, descriptions and propositions.

D. "English language learners" (ELL) means a student whose first or heritage language is not English and who is unable to read, write, speak, or understand English at a level comparable to grade-level English proficient peers and native English speakers.

E. "Heritage language" means a language other than English that is inherited from a family, tribe, community or country of origin.

F. "Language domains" means the four main subdivisions of language: listening, speaking, reading and writing.

G. "Levels of English language proficiency" means the arbitrary division of the second language acquisition continuum into stages of language development.

H. "Listening" means the ability to process, understand, interpret and evaluate spoken language in a variety of situations.

I. "Reading" means the

ability to process, understand, interpret and evaluate written language, symbols and text with understanding and fluency.

J. "Speaking" means oral communication used in a variety of situations for a variety of purposes and audiences.

K. "Writing" means written communication used in a variety of forms for a variety of purposes and audiences.
[6.29.5.7 NMAC - N, 08-31-2009]

6.29.5.8 ENGLISH LANGUAGE DEVELOPMENT STANDARDS GRADE SPANS: The New Mexico English language development standards are organized into five grade spans: PreK-K, 1-2, 3-5, 6- 8, and 9-12.
[6.29.5.8 NMAC - N, 08-31-2009]

6.29.5.9 ENGLISH LANGUAGE DEVELOPMENT STANDARDS PROFICIENCY LEVELS AND LANGUAGE DOMAINS: The English language development standards have five general levels of English language proficiency: "entering" (level 1)," "emerging" (level 2)," "developing" (level 3)," ""expanding" (level 4), "bridging" (level 5)." Reading, writing, listening and speaking skills are addressed at each proficiency level. Comprehension skills are assessed through the analysis of student performance on reading and listening assessments.
[6.29.5.9 NMAC - N, 08-31-2009]

6.29.5.10 CONTENT STANDARDS FOR ENGLISH LANGUAGE DEVELOPMENT, Grades PreK-12: The New Mexico English language development content standards distinguish five general standards: "Social and instructional language," "The language of language arts," "the language of mathematics," "the language of science," and "the language of social studies." Reading, writing, listening and speaking skills are addressed in each standard. Comprehension skills are assessed through the analysis of student performance on reading and listening assessments.

A. English language proficiency standard 1: PreK- 12. Social and instructional language: English language learners communicate for social and instructional purposes within the school setting.

(1) Listening: Process, understand, interpret and evaluate spoken language in a variety of situations.

(2) Speaking: Engage in oral communication in a variety of situations for a variety of purposes and audiences.

(3) Reading: Process, understand, interpret and evaluate written language, symbols, and text with understanding and fluency.

(4) Writing: Engage in written communication in a variety of situations for a variety of purposes and audiences.

B. English language proficiency standard 2: PreK-12. The language of language arts: English language learners communicate information, ideas and concepts necessary for academic success in the content area of language arts.

(1) Listening: Process, understand, interpret and evaluate spoken language in a variety of situations.

(2) Speaking: Engage in oral communication in a variety of situations for a variety of purposes and audiences.

(3) Reading: Process, understand, interpret and evaluate written language, symbols, and text with understanding and fluency.

(4) Writing: Engage in written communication in a variety of situations for a variety of purposes and audiences.

C. English language proficiency standard 3: PreK-12. The language of mathematics: English language learners communicate information, ideas and concepts necessary for academic success in the content area of mathematics.

(1) Listening: Process, understand, interpret and evaluate spoken language in a variety of situations.

(2) Speaking: Engage in oral communication in a variety of situations for a variety of purposes and audiences.

(3) Reading: Process, understand, interpret and evaluate written language, symbols, and text with understanding and fluency.

(4) Writing: Engage in written communication in a variety of situations for a variety of purposes and audiences.

D. English language proficiency standard 4: PreK-12. The language of science: English language learners communicate information, ideas and concepts necessary for academic success in the content area of science.

(1) Listening: Process, understand, interpret and evaluate spoken language in a variety of situations.

(2) Speaking: Engage in oral communication in a variety of situations for a variety of purposes and audiences.

(3) Reading: Process, understand, interpret and evaluate written language, symbols, and text with understanding and fluency.

(4) Writing: Engage in written communication in a variety of situations for a variety of purposes and audiences.

E. English language proficiency standard 5: PreK-12. The language of social studies: English language learners communicate information, ideas and concepts necessary for academic success in the content area of social studies.

(1) Listening: Process, understand, interpret and evaluate spoken language in a variety of situations.

(2) Speaking: Engage in oral communication in a variety of situations for a variety of purposes and audiences.

(3) Reading: Process, understand, interpret and evaluate written language, symbols, and text with understanding and fluency.

(4) Writing: Engage in written communication in a variety of situations for a variety of purposes and audiences.
[6.29.5.10 NMAC - N, 08-31-2009]

HISTORY OF 6.29.5 NMAC:

Pre-NMAC HISTORY: The material in this part is derived from that previously filed with the State Records Center:

SDE 74-17, (Certificate No. 74-17), Minimum Educational Standards for New Mexico Schools, filed April 16, 1975.

SDE 76-9, (Certificate No. 76-9), Minimum Education Standards for New Mexico Schools, filed July 7, 1976.

SDE 78-9, Minimum Education Standards for New Mexico Schools, filed August 17, 1978.

SBE 80-4, Educational Standards for New Mexico Schools, filed September 10, 1980.

SBE 81-4, Educational Standards for New Mexico Schools, filed July 27, 1981.

SBE 82-4, Educational Standards for New Mexico Schools, Basic and Vocational Program Standards, filed November 16, 1982.

SBE Regulation No. 83-1, Educational Standards for New Mexico Schools, Basic and Vocational Program Standards, filed June 24, 1983.

SBE Regulation 84-7, Educational Standards for New Mexico Schools, Basic and Vocational Program Standards, filed August 27, 1984.

SBE Regulation 85-4, Educational Standards for New Mexico Schools, Basic, Special Education, and Vocational Programs, filed October 21, 1985.

SBE Regulation No. 86-7, Educational Standards for New Mexico Schools, filed September 2, 1986.

SBE Regulation No. 87-8, Educational Standards for New Mexico Schools, filed February 2, 1988.

SBE Regulation No. 88-9, Educational Standards for New Mexico Schools, filed October 28, 1988.

SBE Regulation No. 89-8, Educational Standards for New Mexico Schools, filed November 22, 1989.

SBE Regulation No. 90-2, Educational Standards for New Mexico Schools, filed September 7, 1990.

SBE Regulation No. 92-1, Standards for Excellence, filed January 3, 1992.

History of Repealed Material:

6.30.2 NMAC, Standards for Excellence,

filed November 2, 2000 - Repealed effective August 15, 2009.

NMAC History:
6 NMAC 3.2, Standards for Excellence, filed October 17, 1996.
6.30.2 NMAC, Standards for Excellence, November 2, 2000, replaced by 6.29.1 NMAC, General Provisions; 6.29.2 NMAC, Arts Education; 6.29.3 NMAC, Career and Technical Education; 6.29.4 NMAC, English Language Arts; 6.29.5 NMAC, English Language Development; 6.29.6 NMAC, Health Education; 6.29.7 NMAC, Mathematics; 6.29.8 NMAC, Modern, Classical and Native Languages; 6.29.9 NMAC, Physical Education; 6.29.10 NMAC, Science; 6.29.11 NMAC, Social Studies.

NEW MEXICO PUBLIC REGULATION COMMISSION
INSURANCE DIVISION

TITLE 13 INSURANCE
CHAPTER 10 H E A L T H INSURANCE
PART 25 2010 MEDICARE SUPPLEMENT INSURANCE STANDARDS

13.10.25.1 ISSUING AGENCY: New Mexico Public Regulation Commission Insurance Division.
[13.10.25.1 NMAC - N, 08/31/09]

13.10.25.2 SCOPE:

A. Except as otherwise specifically provided in Sections 7, 13, 14, 17 and 22 of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, this regulation shall apply to:

(1) all medicare supplement policies delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010; and

(2) all certificates issued under group medicare supplement policies, which certificates have been delivered or issued for delivery in this state.

B. This regulation shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.
[13.10.25.2 NMAC - N, 08/31/09]

13.10.25.3 S T A T U T O R Y AUTHORITY: Sections 59A-2-9 and 59A-24A-1 et seq. NMSA 1978.
[13.10.25.3 NMAC - N, 08/31/09]

13.10.25.4 D U R A T I O N : Permanent.
[13.10.25.4 NMAC - N, 08/31/09]

13.10.25.5 EFFECTIVE DATE: August 31, 2009, unless a later date is cited at the end of a section.
[13.10.25.5 NMAC - N, 08/31/09]

13.10.25.6 OBJECTIVE: The purpose of this regulation is to provide for the reasonable standardization of coverage and simplification of terms and benefits of medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness insurance coverage to persons eligible for medicare.
[13.10.25.6 NMAC - N, 08/31/09]

13.10.25.7 D E F I N I T I O N S : Except as otherwise specifically noted below, apply Section 4. Definitions of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act.

A. "C o m m i s s i o n e r" means the New Mexico superintendent of insurance.

B. "Insolvency" means:

(1) any organization, when it is unable to meet its obligations as they mature; or

(2) a stock insurer or other stock corporation, when its assets are in amount less than its liabilities, exclusive of paid-in capital stock; or

(3) a mutual, reciprocal, or foreign Lloyds insurer, when its assets are in amount less than its liabilities exclusive of the minimum paid-in basic capital required under Section 59A-5-16 NMSA 1978, for its authority to transact insurance; or

(4) a domestic Lloyds insurer, nonprofit health care plan, prepaid dental care plan, motor club, or other corporation other than any referred to in Paragraphs (2) or (3) of this subsection, when its assets are in an amount less than its liabilities, exclusive of surplus, guaranty fund or deposit required to be maintained under the Insurance Code for its authority to transact insurance in this state; or

(5) as otherwise defined under Section 59A-41-11 NMSA 1978, if in the future Subsection B of 13.10.25.7 NMAC conflicts with this statutory provision.

C. "Pre-standardized medicare supplement benefit plan," "pre-standardized benefit plan" or **"pre-standardized plan"** means a group or individual policy of medicare supplement insurance issued for delivery prior to July 1, 1992.

D. "1990 standardized medicare supplement benefit plan," "1990 standardized benefit plan" or "1990 plan" means a group or individual policy of medicare supplement insurance issued for delivery on or after July 1, 1992 and with an effective date for coverage prior to June 1, 2010 and includes medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.
[13.10.25.7 NMAC - N, 08/31/09]

13.10.25.8 ADOPTION OF THE NAIC MODEL REGULATION OF MEDICARE SUPPLEMENTAL INSURANCE:

A. This rule adopts by reference the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, as recognized by the department of health and human services, centers for medicare & medicaid services in volume 74, no. 78 of the United States federal register, published on April 24, 2009, and as further amended by this rule.

B. In this rule, each provision is numbered to correspond with the numbering of NAIC model standards for regulation of medicare supplemental insurance.

C. This rule is to be applied in conjunction with 13.10.8 NMAC, which continues to serve as the regulatory authority for medicare supplemental policies issued in New Mexico with an effective date for coverage prior to June 1, 2010.
[13.10.25.8 NMAC - N, 08/31/09]

13.10.25.9 Section 5. POLICY DEFINITIONS AND TERMS. See this section of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act.
[13.10.25.9 NMAC - N, 08/31/09]

13.10.25.10 SECTION 6. POLICY PROVISIONS. See this section of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act.
[13.10.25.10 NMAC - N, 08/31/09]

13.10.25.11 Section 7. MINIMUM BENEFIT STANDARDS FOR PRE-STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY PRIOR TO JULY 1, 1992: See this section of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards

Model Act, and as further amended by adding the following sentence at the end of Section 7(A)(3): "An increase in premium shall not be effective without sixty (60) days notice to the policyholder."
[13.10.25.11 NMAC - N, 08/31/09]

13.10.25.12 Section 8. BENEFIT STANDARDS FOR 1990 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED OR DELIVERED ON OR AFTER JULY 1, 1992 AND WITH AN EFFECTIVE DATE FOR COVERAGE PRIOR TO JUNE 1, 2010: See this section of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, and as further amended as follows:

A. Section 8(A)(3) of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act is modified by adding at the end of Section 8(A)(3) the following sentence: "An increase in premium shall not be effective without sixty (60) days notice to the policyholder."

B. Section 8(A)(7)(c) of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act is modified to include at the end of Section 8(A)(7)(c) the last sentence: "and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan".
[13.10.25.12 NMAC - N, 08/31/09]

13.10.25.13 Section 8.1 BENEFIT STANDARDS FOR 2010 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1, 2010: See this section of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, with the following modifications.

A. Section 8.1 - introductory paragraph. Delete the first line and replace with: The following standards are applicable to all medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. Delete the last two lines and replace with the following: No issuer may offer any medicare supplement benefit plan, as described in and subject to the requirements of 13.10.8 NMAC, for sale on or after June 1, 2010. Benefit standards applicable to medicare supplement policies and certificates issued with an effective date for coverage before June 1, 2010 remain subject to the requirements of 13.10.8 NMAC.

B. Section 8.1(A)(3) is modified by adding at the end of Section 8.1(A)(3) the following sentence: "An increase in premium shall not be effective without sixty (60) days notice to the policyholder."

C. Section 8.1(A)(7)(c) is modified to add at the end of the last line of Section 8.1(A)(7)(c) the following: **"**and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan".
[13.10.25.13 NMAC - N, 08/31/09]

13.10.25.14 Section 9. STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 1990 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY ON OR AFTER JULY 1, 1992 AND WITH AN EFFECTIVE DATE FOR COVERAGE PRIOR TO JUNE 1, 2010: See this section of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act.
[13.10.25.14 NMAC - N, 08/31/09]

13.10.25.15 Section 9.1. STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 2010 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1, 2010: See this section of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, with the following:

A. Section 9.1, at the end of the last sentence of the first paragraph add: 13.10.8 NMAC.

B. The following standards are applicable to all medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to medicare supplement policies and certificates issued with an effective date for coverage before June 1, 2010 remain subject to the requirements of 13.10.8 NMAC.
[13.10.25.15 NMAC - N, 08/31/09]

13.10.25.16 Section 10. MEDICARE SELECT POLICIES AND CERTIFICATES. See this section of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act.
[13.10.25.16 NMAC - N, 08/31/09]

13.10.25.17 Section 11. OPEN ENROLLMENT. See this section of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act.
[13.10.25.17 NMAC - N, 08/31/09]

13.10.25.18 Section 12. GUARANTEED ISSUE FOR ELIGIBLE PERSONS. See this section of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, with the following: Section 12(B)(1) is modified to state that an eligible person is **"**enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under medicare; and the plan terminates, or the plan ceases to provide substantially all or all such supplemental health benefits to the individual".
[13.10.25.18 NMAC - N, 08/31/09]

13.10.25.19 Section 13. Standards for Claims Payment: See this section of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act.
[13.10.25.19 NMAC - N, 08/31/09]

13.10.25.20 Section 14. Loss Ratio Standards and Refund or Credit of Premium: See this section of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, and as follows:

A. Section 14(A)(3) is deleted and replaced with: "For purposes of applying Subsection A(1) of this section and Subsection C(3) of Section 15 only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be group policies".

B. Section 14(A)(4)(b) applies to policies issued prior to July 1, 1992.

C. Section 14(B)(3), with the following applicable dates: For the purposes of this section, policies or certificates issued prior to July 1, 1992, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after August 31, 2009. The first report shall be due by May 31, 2012.

D. Section 14(C) applies to an issuer of medicare supplement policies and certificates issued before or after the effective date of 13.10.25 NMAC.

E. Section 14(D) refers to requests made for an increase in a rate for a policy form or certificate form issued before or after the effective date of 13.10.25 NMAC.
[13.10.25.20 NMAC - N, 08/31/09]

13.10.25.21 Section 15. Filing and Approval of Policies and Certificates and Premium Rates. See this section of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act.
[13.10.25.21 NMAC - N, 08/31/09]

13.10.25.22 Section 16. Permitted Compensation Arrangements. See this section of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act.
[13.10.25.22 NMAC - N, 08/31/09]

13.10.25.23 Section 17. Required Disclosure Provisions. See this section of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act.
[13.10.25.23 NMAC - N, 08/31/09]

13.10.25.24 Section 18. Requirements for Application Forms and Replacement Coverage. See this section of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act.
[13.10.25.24 NMAC - N, 08/31/09]

13.10.25.25 Section 19. Filing Requirements for Advertising. See this section of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act.
[13.10.25.25 NMAC - N, 08/31/09]

13.10.25.26 Section 20. Standards for Marketing. See this section of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, with the following addition to Section 20(B): that all prohibitions and requirements in 59A-16-1 et seq. NMSA 1978 and 57-12-1 et seq. NMSA 1978, and accompanying regulations apply to medicare supplement insurance policies and certificates.
[13.10.25.26 NMAC - N, 08/31/09]

13.10.25.27 Section 21. Appropriateness of Recommended Purchase and Excessive Insurance. See this section of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act.
[13.10.25.27 NMAC - N, 08/31/09]

13.10.25.28 Section 22. Reporting of Multiple Policies. See this section of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act
[13.10.28.28 NMAC - N, 08/31/09]

13.10.25.29 Section 23. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates. See this section of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act.
[13.10.25.29 NMAC - N, 08/31/09]

13.10.25.30 Section 24. Prohibition Against Use of Genetic Information and Requests for Genetic Testing. See 13.10.24 NMAC.
[13.10.25.30 NMAC - N, 08/31/09]

13.10.25.31 Section 25. Separability. See this section of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act.
[13.10.25.31 NMAC - N, 08/31/09]

13.10.25.32 Attachment One. See this attachment to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, with the following: Delete the headline and replace with "**Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010**."
[13.10.25.32 NMAC - N, 08/31/09]

HISTORY OF 13.10.13 NMAC: [RESERVED]

NEW MEXICO DEPARTMENT OF PUBLIC SAFETY

TITLE 10 PUBLIC SAFETY AND LAW ENFORCEMENT
CHAPTER 10 DRUG CONTROL PROGRAMS
PART 3 APPLICATION PROCEDURES GOVERNING THE EDWARD BYRNE MEMORIAL JUSTICE ASSISTANCE GRANT PROGRAM

10.10.3.1 ISSUING AGENCY: Department of Public Safety
[10.10.3.1 NMAC - N, 8/31/2009]

10.10.3.2 SCOPE: All eligible Edward Byrne Justice Assistance Grant Program (JAG) applicants.
[10.10.3.2 NMAC - N, 8/31/2009]

10.10.3.3 STATUTORY AUTHORITY: P.L. 108-447, Consolidated Appropriations Act, 2005; NMSA. 1978 Section 9-19-6.
[10.10.3.3 NMAC - N, 8/31/2009]

10.10.3.4 DURATION: Subject to award by federal agency.
[10.10.3.4 NMAC - N, 8/31/2009]

10.10.3.5 EFFECTIVE DATE: August 31, 2009 unless a later date is cited at the end of a section.
[10.10.3.5 NMAC - N, 8/31/2009]

10.10.3.6 OBJECTIVE:

A. The U.S. department of justice, bureau of justice assistance (BJA), under the Consolidated Appropriations Act, 2005, Public Law 108-447 provides states and units of local government with funds to provide additional personnel, equipment, supplies, contractual support, training, technical assistance, and information systems for criminal justice.

B. This initiative is intended to add to, augment or supplement, not replace, resources already committed to the drug and violent crime control effort.
[10.10.3.6 NMAC - N, 8/31/2009]

10.10.3.7 DEFINITIONS: Reserved
[10.10.3.7 NMAC - N, 8/31/2009]

10.10.3.8 ELIGIBLE APPLICANTS:

A. Eligible applicants are limited to state agencies and local units of government. A unit of local government is : a town, township, village, parish, city, county, or other general purpose political subdivision of a state; any law enforcement district or judicial enforcement district that is established under applicable state law and has authority to, in a manner independent of other state entities, establish a budget and impose taxes; or federally recognized Indian tribe or Alaskan native organization that performs law enforcement functions as determined by the secretary of the interior. State institutions of higher learning are considered to be "state agencies" for eligibility purposes. In addition, local units of government who are eligible to receive a direct award through the bureau of justice assistance are not eligible to apply to the department of public safety for JAG funding. The department of public safety will accept applications for private or for profit businesses, limited to the evaluation component only.

B. Previous grant recipients shall be in compliance with the stipulations of all previous awards in order to continue to be eligible.
[10.10.3.8 NMAC - N, 8/31/2009]

10.10.3.9 HOW TO APPLY: To obtain an application packet in either electronic form or hard copy, contact: the grants management bureau, department of public safety, 4491 Cerrillos Road, Post Office Box 1628, Santa Fe, New Mexico 87504-1628 or by calling (505) 827-3347 or (505) 827-9112.
[10.10.3.9 NMAC - N, 8/31/2009]

10.10.3.10 DISTRIBUTION OF FORMULA FUNDS: Variable pass-through: A minimum of 49.29% must be passed through to local units of government (as defined in 10.10.3.8 NMAC). States may exceed the minimum pass-through by providing funds not used at the state level to local units of government.
[10.10.3.10 NMAC - N, 8/31/2009]

10.10.3.11 AUTHORIZED PROJECTS/PROGRAM AREAS:

A. Authorized programs for funding are listed below. Approved program purpose areas:

(1) law enforcement;

(2) planning, evaluation and technology improvement programs.

B. Applicants may request copies of the New Mexico drug strategy by writing the department of public safety, grants management bureau, Post Office Box 1628, Santa Fe, New Mexico 87504 or by calling (505) 827-3347 or (505) 827-9112.
[10.10.3.11 NMAC - N, 8/31/2009]

10.10.3.12 APPLICATION REQUIREMENTS: All applicants for funding under the JAG formula grant program must adhere to the following procedures.

A. Application deadline: All applications must be received at the grants management bureau, department of public safety postmarked or hand-delivered no later than 5:00 P.M. on the date stated in the application. It is the responsibility of the applicant to ensure that the application is received by the grants management bureau, department of public safety. Any application not received or postmarked by the deadline indicated in the application will not be considered.

B. Each applicant shall forward **an original and six copies** of the application to the grants management bureau, 4491 Cerrillos Road, Post Office Box 1628, Santa Fe, New Mexico 87504-1628, phone number (505) 827-3347.

C. Single purpose area rule: Only applications proposing to carry out a project in one single program will be accepted for funding consideration.

D. Proposed project term: The term of the project proposed in the application shall be fully disclosed in the application. The state recognizes that continued funding of successful projects is paramount to the success of the overall program. Projects should be designed to be consistent with the multi-year state strategy.

E. Certification requirements: Drug free workplace requirement: This applies to state agencies **ONLY**. Title V, Section 5153, of the Anti-Drug Abuse Act of 1988 provides that all state agencies receiving federal funds shall certify and submit proof to the granting agency that it will provide a drug-free workplace.

F. Debarment, suspension, ineligibility, and voluntary exclusion: All applicants for funds will be required to complete a certification stating that the applicant has not been suspended, debarred, or is otherwise ineligible to participate in this federal program.

G. Disclosure of lobbying activities requirement: Section 319 of Public Law 101-121 generally prohibits recipients of federal contracts, grants and loans from using appropriated funds for lobbying the executive or legislative branches of the federal government in connection with a specific contract, grant or loan. Section 319 also requires each person who requests or receives a federal contract, grant, cooperative agreement, loan or a federal commitment to insure or grant a loan, to disclose lobbying. The term "recipient" as used in this context does not apply to Indian tribes, organizations, or agencies.

H. Disclosure of federal participation requirement: Section 8136 of the Department of Defense Appropriations Act (Stevens Amendment) enacted in October 1988, requires that when issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs funded in whole or in part with federal money, all grantees receiving federal funds, including but not limited to state and local governments, shall clearly state (1) the percentage of the total cost of the program or project which will be financed with federal money, and (2) the dollar amount of federal funds for the project or program. This applies only to subgrantees who receive $500,000 or more in the aggregate during a single funding year.

I. General financial requirements: Grants funded under the formula grant program are governed by the provisions of 28 CFR Part 66, Common Rule, Uniform Administrative Requirements for Grants and Cooperative Agreements with State and Local Government and the office of management and budget (OMB) circulars applicable to financial assistance. These circulars along with additional information and guidance contained in "OJP financial guide for grants" (current edition), are available from OJP and from the grants management bureau. This guideline manual provides information on cost allowability, methods of payment, audits, accounting systems and financial records.

J. Audit requirement: Agencies applying for federal funds must assure that they will comply with the appropriate audit requirement. Subgrantees expending $500,000 or more in a fiscal year in all sources of federal funding shall have a single-organizationwide audit conducted in accordance with OMB circular A-133, as amended.

K. Confidential funds requirement: State agencies and local units of government may apply for and receive grants to conduct law enforcement undercover operations. Each agency must certify that it will develop policies and procedures to protect the confidentiality of the operations. Agencies must also certify that they will comply with the office of justice programs financial guide current edition.

L. Civil rights requirement: The applicant certifies that it will comply with the non-discrimination requirements of the Omnibus Crime Control and Safe Streets Act of 1968, as amended; Title II of the Americans With Disabilities Act of 1990 42 U.S.C. 12131; Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973, as amended; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Department of Justice Nondiscrimination Regulations 28 CFR Part 35 and 42, Subparts C, D, E and G; and Executive Order 11246, as amended by Executive Order 11375, and their implementing regulations. This applicant further certifies that if a federal or state court or the administrative agency makes a finding of discrimination, it will immediately forward a copy of the finding to the grantor agency, for submission to the office of civil rights, office of justice programs, U.S. department of justice within 30 days of receipt.
[10.10.3.12 NMAC - N, 8/31/2009]

10.10.3.13 APPLICATION PARTS: The application must include all of the following parts in order to be considered for this funding.

A. Title page: Name of agency, project title, and purpose area.

B. Coversheet: Application (lead agency), address, county/counties served, congressional district, contact person, contact person telephone number, agency type, application type, joint application, federal grant funds requested, program area, and certification.

C. Table of contents: The table of contents should list the contents of the application, in the order in which they appear.

D. General overview:

State a general overview of the program, to include what your program will accomplish, keeping it simple and to the point.

E. Problem statement: Should include, but not limited to: description of the geographic area affected; description of the problem; who does the problem affect; how will program address the problem; and, provide statistical data to reinforce problem data.

F. Goals, objectives, and methods of accomplishments: Explain the goal of the project in simple and straight-forward terms; one or two goals specifically related to the program's purpose area are sufficient. Each goal should have at least one measureable output linked to a desired outcome. The goals, objectives, and methods of accomplishments must include:

(1) project objectives that are linked to meaningful and measureable outcomes consistent with the goals of the Edward Byrne memorial justice assistance program;

(2) organization capabilities and competencies, including a description of how the organization will track all drawdowns and grant expenditures separately from other funding sources;

(3) project evaluation: the evaluation must tie to the objectives and the BJA established performance measures; applicants will be responsible for answering the following questions: How will you know the project is working? How will you determine if you are meeting your objectives?

G. Sustainment: Explain how the project will continue operations after the termination of this award. There is no guarantee grant funds will be available for your project in the future. Provide a detailed summary of the plan to continue operations when funds are not available or are significantly reduced.

H. Statement of coordination and funding: State participating agencies involved or have an interest in this program. State other funding sources available to your program and explain how you will coordinate all funding sources to maximize program impact. Multi-jurisdictional task forces must provide a joint powers agreement (JPA) or a memorandum of understanding (MOU). Letters of support must be addressed to the cabinet secretary and included in the application, but not mailed to the secretary directly. Letters of commitment should be addressed to the head of the agency applying for the funds. JPAs and MOUs must be signed by all agencies participating in joint applications. Attachments, such as JPA's and MOU's will be submitted in this section.

I. Budget detail and budget narrative: The budget detail is limited to the following categories: personnel, fringe benefits, contractual services, travel, equipment, supplies, administrative costs, confidential funds, and other costs. Round amounts up to the nearest dollar. The budget narrative explains how the costs were estimated and justifies the need for the cost.

J. Slide presentation: A 15 minute presentation in front of the reviewing panel may be required, demonstrating the project's goals, objectives, and methods of accomplishments; followed by a question and answer session. Agencies will be notified of the date and place of each presentation.
[10.10.3.13 NMAC - N, 8/31/2009]

10.10.3.14 APPLICATION FORMAT: All applications should follow the format outlined below:

A. Applications should be typewritten except for the coversheet. The original copy must be stapled in the upper left hand corner and two-hole punched at the top.

B. Applications are to be typed, single spaced. Font size must be comparable in size to 12 point times roman or courier.

C. Adhere to page limits for each part of the grant application.

D. Place footer in lower right hand corner with a project title and page number.

E. Include all required forms, such as signed certifications.
[10.10.3.14 NMAC - N, 8/31/2009]

10.10.3.15 ALLOWABLE / UNALLOWABLE EXPENSES: In order to ensure the most efficient and effective use of grant funds, applicants must adhere to the following.

A. Administrative expenses: Applicants shall limit total administrative expenses to no more than five percent (5%) of their grant award. The cost of operating and maintaining facilities, depreciation, and administrative salaries are examples of administrative costs.

B. General salaries and personnel costs: Payment of personnel costs with grant funds is permitted if the costs are part of an approved program or project. Applicants must provide a copy of their agency's overtime policy with the grant application for review and prior approval by the department of public safety prior to overtime reimbursement. General salary and personnel costs must:

(1) reflect an after-the-fact distribution of the actual activity of each employee;

(2) account for the total activity for which each employee is compensated.

C. Expenditures for purchase of services, evidence, and information (confidential funds): Formula grant funds which may be used for confidential expenditures are defined as funds used for the purchase of services, purchase of physical evidence and information, including buy money, flash rolls, etc. Guidelines related to confidential expenditures are found in OJP financial guide for grants. The grants management bureau has the authority to approve the allocation, use, and expenditure of formula funds for confidential expenditures. **All applications containing projects which utilize funds for confidential expenditures must contain an assurance that the guidelines found in OJP financial guide for grants will be followed**.

D. Land acquisition: Acquisition of land with grant funds is prohibited.

E. Audit costs: Expenses associated with conducting audits of programs/projects funded with formula grants are allowable expenses and may be paid with administrative funds, program funds, or a combination of both.

F. Non-supplanting: Formula grant funds shall not be used to supplant applicant funds, but will be used to increase the amount of such funds that would, in the absence of federal aid, be made available for law enforcement activities.

G. Participation in drug enforcement administration task forces: Formula grant funds may be used for expenses associated with participation of the state or units of local government, or combination thereof, in the state and local task force program established by the drug enforcement administration (Section 504 (c) of the act).
[10.10.3.15 NMAC - N, 8/31/2009]

10.10.3.16 REPORTING AND OTHER REQUIREMENTS:

A. Accountability and transparency: a strong emphasis will be placed on accountability and transparency, it is essential that all funds be tracked, accounted for, and reported. Sub-recipients must be prepared to track and report on the specific outcomes and benefits attributable. Each sub-recipient will be responsible for having completed reports sent to the grants management bureau **no later than five days after the end of each calendar quarter**. Each recipient that received JAG funds shall submit a report to the grants management bureau that contains:

(1) the total amount of JAG funds received;

(2) the amount of JAG funds that was expended or obligated;

(3) a detailed list of all projects or activities for which JAG funds were expended or obligated;

(a) the name of the project or activity;

(b) a description of the project or

activity;

(c) an evaluation of the completion status of the project or activity; and,

(d) for infrastructure investments made by state or local governments, the purpose, total cost, and rationale of the agency for funding the infrastructure investment with funds made available under this act, and the name of the person to contact at the agency if there are concerns with the infrastructure investment.

B. Detailed information to include the data elements required to comply with the Federal Funding Accountability and Transparency Act of 2006 (Public Law 109-282), allowing aggregate reporting on awards below $25,000 or to individuals, as prescribed by the director to the office of management and budget.

C. To assist in fulfilling the accountability objectives, as well as the department's responsibilities under the Government Performance and Results Act of 1993 (GPRA), (Public Law 103-62), applicants who receive funding under this solicitation must provide data that measures the result of their work.

D. Recipients will also be required to submit quarterly progress reports, either semi-annually or annually. **The department of public safety may withhold the reimbursement of funds if any award recipient is delinquent in submitting the required progress reports**.

E. Financial requirements: Recipient agrees to comply with the financial and administrative requirements set forth in the current edition of the office of justice programs (OJP) financial guide.

F. Audit requirements: The recipient agrees to comply with the organizational audit of OMB circular A-133, audit of states, local government, and non-profit organizations, as further described in the current edition of the OJP financial guide, chapter 19.

G. Non-supplanting: Formula grant funds shall not be used to supplant applicant funds, but will be used to increase the amount of such funds that would, in the absence of federal aid, is made available for law enforcement activities.
[10.10.3.16 NMAC - N, 8/31/2009]

10.10.3.17 RATING CRITERIA: Rating will be based on the following parts:

A. coversheet;

B. table of contents;

C. page limitation;

D. general overview;

E. problem statement;

F. goals, objectives, and methods of accomplishments;

G. project evaluation;

H. sustainment;

I. statement of coordination;

J. budget detail and budget narrative;

K. slide presentation (maybe required, see application for details).
[10.10.3.17 NMAC - N, 8/31/2009]

10.10.3.18 SELECTION PROCESS: The department of public safety will make a decision on each complete application. The failure of an application to conform to state program priorities or to meet criteria set forth in this document may constitute reason for disapproval. The selection process is as follows.

A. Upon receipt of applications, the grants management bureau staff will review the applications for eligibility, completeness, and compliance.

B. Eligible applications will be forwarded to a panel for review and rating. The selection panel through the grants management bureau will submit their recommendations for consideration to the cabinet secretary.

C. The cabinet secretary of the department of public safety has the final authority in the awarding of grants.

D. All applicants will be notified in writing of the outcome of their application no later than 30 days after the application deadline.

E. Unsuccessful applications may appeal if the applicant feels any federal or state regulation involving selection was violated. Appeals must be received by the New Mexico department of public safety, grants management bureau within 15 calendar days of receipt of the outcome notification. A three-member appeal panel shall review the alleged violation, decide on its validity, and make a recommendation to the cabinet secretary of the department of public safety. If an appeal is received by the department of public safety all funding decisions will be delayed until the appeal has been reviewed and a final decision has been made by the cabinet secretary. The cabinet secretary's decision shall be final.

F. The New Mexico department of public safety reserves the right to reduce any request based on funding availability and other factors as determined by the New Mexico department of public safety.
[10.10.3.18 NMAC - N, 8/31/2009]

10.10.3.19 SUSPENSION AND TERMINATION OF FUNDING: The state may, after reasonable notice and failure of informal efforts to effect resolution, suspend, in whole or in part, or after reasonable notice and opportunity for a hearing, terminate, in whole or in part, funding for program or project which fails to conform to the requirements or statutory objectives the program or financial regulations and policies or the terms and conditions of its grant award. Hearing and appeal procedures for termination actions are set forth in department of justice regulations at 28 CFR part 18.
[10.10.3.19 NMAC - N, 8/31/2009]

HISTORY OF 10.10.3 NMAC: [RESERVED]

NEW MEXICO DEPARTMENT OF PUBLIC SAFETY

This is an amendment to 10.10.2 NMAC, Sections 3, 8, 10, 11, 13, 14 and 19, effective 8-31-09. This also amends the part name.

TITLE 10 PUBLIC SAFETY AND LAW ENFORCEMENT
CHAPTER 10 DRUG CONTROL PROGRAMS
PART 2 [~~APPLICATIONS~~] APPLICATION PROCEDURES GOVERNING THE RECOVERY AND REINVESTMENT: EDWARD BYRNE MEMORIAL JUSTICE ASSISTANCE GRANT PROGRAM

10.10.2.3 STATUTORY AUTHORITY: NMSA 1978 Section 9-19-6 [~~the U.S. department of justice, bureau of justice assistance (BJA), under the American Recovery and Reinvestment Act of 2009 (ARRA), (Public Law 111-5) (the "Recovery Act") and by 42 U.S.C 3751 (a)~~].
[10.10.2.3 NMAC - Rp 10 NMAC 10.2.3, 3-15-00; A, 07-29-05; A, 4-15-09; A, 8-31-09]

10.10.2.8 ELIGIBLE APPLICANTS: Eligible applicants are limited to [~~state agencies and~~] local units of government only. A unit of local government is : a town, township, village, parish, city, county, or other general purpose political subdivision of a state; any law enforcement district or judicial enforcement district that is established under applicable state law and has authority to, in a manner independent of other state entities, establish a budget and impose taxes; or federally recognized Indian tribe or Alaskan native organization that performs law enforcement functions as determined by the secretary of the interior. [~~State institutions of higher learning are considered to be "state agencies" for eligibility purposes.~~] In addition, local units of government who are eligible to receive a direct award through the bureau of justice assistance are not eligible to apply to the department of public safety for JAG funding. The department of public safety will accept applications for private or for profit businesses, limited to the evaluation component only.
[10.10.2.8 NMAC - Rp 10 NMAC 10.2.8, 3-15-00; A, 05-31-02; A, 07-29-05; A, 07-

31-07; A, 4-15-09; A, 8-31-09]

10.10.2.10 HOW TO APPLY: Application packets will be available after [~~April 15, 2009~~] August 31, 2009. To obtain a packet in either electronic form or hard copy, contact: the grants management bureau, department of public safety, 4491 Cerrillos Road, Post Office Box 1628, Santa Fe, New Mexico 87504-1628 or by calling (505) 827-3347 or (505) 827-9112. Application packets must be completed in full with appropriate signatures, postmarked or delivered to the grants management bureau by 5:00 P.M. on [~~May 15, 2009~~] September 25, 2009.
[10.10.2.10 NMAC - Rp 10 NMAC 10.2.10, 3-15-00; A, 05-31-02; A, 05-28-04; A, 07-29-05; A, 07-31-07; A, 07-31-08; 10.10.2.10 NMAC - N, 4-15-09; A, 8-31-09]

10.10.2.11 DISTRIBUTION OF FORMULA FUNDS: Variable pass-through: A minimum of 49.29% must be passed through to local units of government (as defined in [~~10.10.8 NMAC~~] 10.10.2.8 NMAC). States may exceed the minimum pass-through by providing funds not used at the state level to local units of government. State funds are available for the evaluation component only.
[10.10.2.11 NMAC - Rp 10 NMAC 10.2.11, 3-15-00; A, 05-31-02; A, 05-28-04; A, 07-29-05; A, 07-31-07; A, 07-31-08; 10.10.2.11 NMAC - Rn & A, 10.10.2.9 NMAC, 4-15-09; A, 8-31-09]

10.10.2.13 APPLICATION REQUIREMENTS: All applicants for funding under the JAG formula grant program must adhere to the following procedures.

A. Application deadline: All applications must be received at the grants management bureau, department of public safety postmarked or hand-delivered no later than 5:00 P.M., [~~May 15, 2009~~] September 25, 2009. It is the responsibility of the applicant to ensure that the application is received by the grants management bureau, department of public safety. Any application not received or postmarked by the deadline will not be considered.

B. Each applicant shall forward **an original and six copies** of the application to the grants management bureau, 4491 Cerrillos Road, Post Office Box 1628, Santa Fe, New Mexico 87504-1628, phone number (505) 827-3347.

C. Single purpose area rule: Only applications proposing to carry out a project in one single program will be accepted for funding consideration.

D. Proposed project term: The term of the project proposed in the application shall be from [~~May 1, 2009 through June 30, 2010~~] October 1, 2009 through June 30, 2011. The state recognizes that continued funding of successful projects is paramount to the success of the overall program. Projects should be designed to be consistent with the multi-year state strategy.

E. Certification requirements: Drug free workplace requirement: This applies to state agencies **ONLY**. Title V, Section 5153, of the Anti-Drug Abuse Act of 1988 provides that all state agencies receiving federal funds shall certify and submit proof to the granting agency that it will provide a drug-free workplace.

F. Debarment, suspension, ineligibility, and voluntary exclusion: All applicants for funds will be required to complete a certification stating that the applicant has not been suspended, debarred, or is otherwise ineligible to participate in this federal program.

G. Disclosure of lobbying activities requirement: Section 319 of Public Law 101-121 generally prohibits recipients of federal contracts, grants and loans from using appropriated funds for lobbying the executive or legislative branches of the federal government in connection with a specific contract, grant or loan. Section 319 also requires each person who requests or receives a federal contract, grant, cooperative agreement, loan or a federal commitment to insure or grant a loan, to disclose lobbying. The term "recipient" as used in this context does not apply to Indian tribes, organizations, or agencies.

H. Disclosure of federal participation requirement: Section 8136 of the Department of Defense Appropriations Act (Stevens Amendment) enacted in October 1988, requires that when issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs funded in whole or in part with federal money, all grantees receiving federal funds, including but not limited to state and local governments, shall clearly state (1) the percentage of the total cost of the program or project which will be financed with federal money, and (2) the dollar amount of federal funds for the project or program. This applies only to subgrantees who receive $500,000 or more in the aggregate during a single funding year.

I. General financial requirements: Grants funded under the formula grant program are governed by the provisions of 28 CFR Part 66, Common Rule, Uniform Administrative Requirements for Grants and Cooperative Agreements with State and Local Government and the office of management and budget (OMB) circulars applicable to financial assistance. These circulars along with additional information and guidance contained in "OJP financial guide for grants" (current edition), are available from OJP and from the grants management bureau. This guideline manual provides information on cost allowability, methods of payment, audits, accounting systems and financial records.

J. Audit requirement: Agencies applying for federal funds must assure that they will comply with the appropriate audit requirement. Subgrantees expending $500,000 or more in a fiscal year in all sources of federal funding shall have a single-organizationwide audit conducted in accordance with OMB circular A-133, as amended.

K. Confidential funds requirement: State agencies and local units of government may apply for and receive grants to conduct law enforcement undercover operations. Each agency must certify that it will develop policies and procedures to protect the confidentiality of the operations. Agencies must also certify that they will comply with the office of justice programs financial guide current edition.

L. Civil rights requirement: The applicant certifies that it will comply with the non-discrimination requirements of the Omnibus Crime Control and Safe Streets Act of 1968, as amended; Title II of the Americans With Disabilities Act of 1990 42 U.S.C. 12131; Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973, as amended; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Department of Justice Nondiscrimination Regulations 28 CFR Part 35 and 42, Subparts C, D, E and G; and Executive Order 11246, as amended by Executive Order 11375, and their implementing regulations. This applicant further certifies that if a federal or state court or the administrative agency makes a finding of discrimination, it will immediately forward a copy of the finding to the grantor agency, for submission to the office of civil rights, office of justice programs, U.S. department of justice within 30 days of receipt.
[10.10.2.13 NMAC - Rp 10 NMAC 10.2.13, 3-15-00; A, 05-31-02; A, 05-28-04; A, 07-29-05; Repealed, 07-31-07; 10.10.2.13 NMAC - Rn & A, 10.10.2.11 NMAC, 4-15-09; A, 8-31-09]

10.10.2.14 APPLICATION PARTS: The application must include all of the following parts in order to be considered for this funding.

A. Title page: (one page limit) Name of agency, project title, and purpose area.

B. Coversheet: (one page limit) Application (lead agency), address, county/counties served, congressional district, contact person, contact person telephone number, agency type, application type, joint application, federal grant funds

requested, program area, and certification.

C. Table of contents: (one page limit) The table of contents should list the contents of the application, in the order in which they appear.

D. General overview: (one page limit) State a general overview of the program, to include what your program will accomplish, keeping it simple and to the point.

E. Problem statement: (no more than five page limit) Should include, but not limited to: description of the geographic area affected; description of the problem; who does the problem affect; how will program address the problem; and, provide statistical data to reinforce problem data.

F. Goals, objectives, and methods of accomplishments: (no page limit) Explain the goal of the project in simple and straight-forward terms, one or two goals specifically related to the program's purpose area are sufficient. Each goal should have at least one measureable output linked to a desired outcome. Additionally, explain how the program will preserve and create jobs as outlined in the Recovery Act. The goals, objectives, and methods of accomplishments must include:

(1) project objectives that are linked to meaningful and measureable outcomes consistent with the goals of the Recovery Act, and the likelihood of achieving such outcomes, such as job creation and preservation;

(2) organization capabilities and competencies, including a description of how the organization will track all drawdowns and grant expenditures separately from other funding sources;

(3) activities that can be started and completed expeditiously, and in a manner that maximizes job creation and economic benefits.

G. Project evaluation: (no more than three page limit) The evaluation must tie to the objectives and the BJA established performance measures. Applicants will be responsible for answering the following questions: How will you know the project is working? How will you determine if you are meeting your objectives?

H. Sustainment: (one page limit) Explain how the project will continue operations after the termination of this award. There is no guarantee grant funds will be available for your project in the future. Provide a detailed summary of the plan to continue operations when funds are not available or are significantly reduced.

I. Statement of coordination and funding: (narrative no more than five page limit) State participating agencies involved or have an interest in this program. State other funding sources available to your program and explain how you will coordinate all funding sources to maximize program impact. [~~Mutli-jurisdictional~~] Multi-jurisdictional task forces must provide a joint powers agreement (JPA) or a memorandum of understanding (MOU). Letters of support must be addressed to the cabinet secretary and included in the application, but not mailed to the secretary directly. Letters of commitment should be addressed to the head of the agency applying for the funds. JPAs and MOUs must be signed by all agencies participating in joint applications.

J. Budget detail and budget narrative (no page limit) The budget detail is limited to the following categories: personnel, fringe benefits, contractual services, travel, equipment, supplies, and other costs. The budget narrative explains how the costs were estimated and justifies the need for the cost.

[10.10.2.14 NMAC - Rp 10 NMAC 10.2.14, 3-15-00; A, 05-31-02; A, 05-28-04; A, 07-29-05; A, 07-31-08; 10.10.2.14 NMAC - N, 4-15-09; A, 8-31-09]

10.10.2.19 SELECTION PROCESS: The department of public safety will make a decision on each complete application [~~45~~] 30 days after the application deadline. Failure to submit a complete application will result in ineligibility. The failure of an application to conform to state program priorities or to meet criteria set forth in this document may constitute reason for disapproval. The selection process is as follows.

A. Upon receipt of applications, the grants management bureau staff will review the applications for eligibility, completeness, and compliance.

B. Eligible applications will be forwarded to a panel for review and rating. The selection panel through the grants management bureau will submit their recommendations for consideration to the cabinet secretary.

C. The cabinet secretary of the department of public safety has the final authority in the awarding of grants.

D. All applicants will be notified in writing of the outcome of their application no later than [~~45~~] 30 days after the application deadline.

E. Unsuccessful applications may appeal if the applicant feels any federal or state regulation involving selection was violated. Appeals must be received by the New Mexico department of public safety, grants management bureau within 15 calendar days of receipt of the outcome notification. A three-member appeal panel shall review the alleged violation, decide on its validity, and make a recommendation to the cabinet secretary of the department of public safety. If an appeal is received by the department of public safety all funding decisions will be delayed until the appeal has been reviewed and a final decision has been made by the cabinet secretary. The cabinet secretary's decision shall be final.

F. The New Mexico department of public safety reserves the right to reduce any request based on funding availability and other factors as determined by the New Mexico department of public safety.

[10.10.2.19 NMAC - Rn & A, 10.10.2.15 NMAC, 4-15-09; A, 8-31-09]

NEW MEXICO REGULATION AND LICENSING DEPARTMENT

FINANCIAL INSTITUTIONS DIVISION

TITLE 12 TRADE, COMMERCE AND BANKING
CHAPTER 19 MORTGAGE LENDING
PART 2 MORTGAGE LOAN ORIGINATOR REQUIREMENTS

12.19.2.1 ISSUING AGENCY: Financial Institutions Division of the Regulation and Licensing Department.
[12.19.2.1 NMAC - N, 08/31/09]

12.19.2.2 SCOPE: All mortgage loan originators licensed by the state of New Mexico.
[12.19.2.2 NMAC - N, 08/31/09]

12.19.2.3 STATUTORY AUTHORITY: New Mexico Mortgage Loan Originator Licensing Act, Chapter 122 Session Law 2009.
[12.19.2.3 NMAC - N, 08/31/09]

12.19.2.4 DURATION: Permanent.
[12.19.2.4 NMAC - N, 08/31/09]

12.19.2.5 EFFECTIVE DATE: August 31,2009, unless a later date is cited in the history note at the end of a section.
[12.19.2.5 NMAC - N, 08/31/09]

12.19.2.6 OBJECTIVE: The objective of this part is to effectuate the purposes of the New Mexico Mortgage Loan Originator Licensing Act, Chapter 122 Session law 2009 and to clarify its meaning.
[12.19.2.6 NMAC - N, 08/31/09]

12.19.2.7 DEFINITIONS:

A. "Independent contractor" means any person who processes or underwrites residential mortgage loans and is not a W-2 employee

of a licensed mortgage loan company.

B. "Takes a residential mortgage loan application", with respect to Chapter 122 Session Law 2009 Section 3(K), means:

(1) any communication, regardless of form, from a mortgage loan originator to a borrower soliciting a loan application or requesting information typically required in an application for the purpose of deciding whether or not to extend the requested offer of a loan to a borrower; or

(2) any communication, regardless of form, from a borrower to a mortgage loan originator, for an offer or responding to a solicitation for an offer of residential mortgage loan terms or providing information typically required in an application for the purpose of deciding whether or not to extend the requested offer of a loan to a borrower

[12.19.2.7 NMAC - N, 08/31/09]

12.19.2.8 FEES: A mortgage loan originator shall pay the following fees to maintain a valid mortgage loan originator license. These fees are non-refundable. These fees are in addition to any fees established and charged by the nationwide mortgage licensing system and registry, any approved educational course provider, any approved educational testing provider, any law enforcement agency for finger prints and background checks or by any credit reporting agency used by the nationwide mortgage licensing system and registry:

(1) application fee: $200.00;

(2) license fee: $200.00;

(3) annual renewal license fee: $200.00;

(4) reinstatement fee: $100.00.

[12.19.2.8 NMAC - N, 08/31/09]

12.19.2.9 SURETY BOND: Every surety bond shall provide that no suit or claim shall be maintained to enforce any liability on the bond unless brought within six years after the act upon which the suit or claim is based.

[12.19.2.9 NMAC - N, 08/31/09]

12.19.2.10 CHALLENGE PROCESS: A mortgage loan originator may challenge information entered by the director into the nationwide mortgage licensing system and registry by requesting a hearing. Hearings requested shall be conducted under the following procedures.

A. The mortgage loan originator shall request a hearing in writing by certified return receipt letter addressed to the director. The director shall, within 30 days of receipt of the request, notify the mortgage loan originator of the date, time and place of the hearing.

B. Hearings shall be conducted pursuant to the Administrative Procedures Act, Sections 12-8-10 and 12-8-11 NMSA 1978.

C. Hearings shall be conducted in Santa Fe county or another county if agreed to by the director and the mortgage loan originator.

D. All hearings shall be conducted by the director or by a hearing officer designated by the director. A hearing officer shall, within 30 days following the hearing, submit to the director a report setting forth the hearing officer's findings of fact and conclusions of law.

E. All hearings shall be open to the public. In cases in which the reputation of an applicant or licensee may be damaged or, for good cause shown, the director or hearing officer may hold a closed hearing and must state the reasons for this decision in the record.

F. A complete record shall be made of all evidence and testimony received during the course of any hearing.

G. Within sixty (60) days after the hearing, the director shall serve upon the applicant or licensee a copy of the final written order.

[12.19.2.10 NMAC - N, 08/31/09]

12.19.2.11 SUCCESSIVE YEARS FOR CONTINUING EDUCATION COURSES: The New Mexico Mortgage Loan Originator Licensing Act, Chapter 122 Session Law 2009 Section 10(E)(2), prohibits a licensed mortgage loan originator from taking the same approved continuing education course in the same or successive years to meet the annual continuing education requirements. For purposes of this limitation, the term "successive years" means the two years following the year in which a mortgage loan originator takes an approved course.

[12.19.2.11 NMAC - N, 08/31/09]

12.19.2.12 REINSTATEMENT OF LICENSE: The license of a mortgage loan originator that expires for failure to satisfy the minimum standards for renewal may be reinstated if the licensee meets the following requirements:

A. The license must be reinstated between January 1 and February 28 of the year immediately following the year the license expired.

B. All continuing education courses and any other minimum requirements for license renewal for the year in which the license expired must be completed by February 28 of the year immediately following the year the license expired.

C. The licensee must pay the applicable licensing, reinstatement and late fees. If a mortgage loan originator whose license has expired fails to meet the requirements for reinstatement specified in this section, the mortgage loan originator must apply for a license and meet the requirements for licensure in effect at that time.

[12.19.2.12 NMAC - N, 08/31/09]

12.19.2.13 DISCLOSURES: At least two (2) days prior to closing, a mortgage loan originator shall provide to the borrower(s) the following federal disclosures specific to the mortgage loan the borrower(s) is receiving: (1) a good faith estimate and (2) a truth in lending statement. These documents shall be used to comply with Chapter 122 Session Law 2009 Section 52 (D) and (E). For the purposes of the act, the yield spread premium or discount points received by the mortgage loan company shall be disclosed as a dollar amount on all good faith estimates.

[12.19.2.13 NMAC - N, 08/31/09]

12.19.2.14 REASONABLE ABILITY TO REPAY: The documentation of "reasonable ability to repay", in Chapter 122 Session Law Section 13(C)(24), will depend upon the totality of facts and circumstances relating to a specific residential mortgage loan transaction and the borrower's financial condition and circumstances. While the documentation of certain residential mortgage loan transactions may clearly demonstrate the borrower's reasonable ability to repay, others may require closer scrutiny to determine whether the documentation for a particular residential mortgage loan transaction sufficiently demonstrates ability to repay. The "reasonable ability to repay" standard shall be demonstrated through reasonably reliable documentation. Reasonably reliable documentation means any documentation that is required by a mortgage loan company to satisfy the requirements of a loan product that meets the borrower's requested terms and qualifications, documents the source of repayment and includes verifiable written documentation obtained from the borrower or a third party. Reasonably reliable documentation may include but may not be limited to verbal verifications.

[12.19.2.14 NMAC - N, 08/31/09]

HISTORY OF 12.19.2 NMAC: [RESERVED]

NEW MEXICO REGULATION AND LICENSING DEPARTMENT

FINANCIAL INSTITUTIONS DIVISION

This is an amendment to 12.15.4 NMAC Sections 6, 7, 8 and 9, effective 08/31/2009.

12.15.4.6 OBJECTIVE: The objective of this part is to establish the [~~debt-to-income ratios and residual income guidelines~~] reasonable ability to repay a home loan required by Section 58-21A-[~~5(H)~~] 4 (C) NMSA 1978.
[12.15.4.6 NMAC - N, 01/30/2004; A, 08/31/09]

12.15.4.7 DEFINITIONS: For purposes of this rule, the definitions set forth in the act and regulations adopted pursuant to the act shall apply unless otherwise noted.

A. "Reasonably reliable documentation" means any documentation that is required by a mortgage loan company to satisfy the requirements of a loan product that meets the borrower's requested terms and qualifications, documents the source of repayment and includes verifiable written documentation obtained from the borrower or a third party. Reasonably reliable documentation may include but may not be limited to verbal verifications.

B. "Relevant financial records" means such reasonably available documents as a borrower's credit application, financial statement, credit report, tax returns, bank account statements, payroll receipts, other third-party income verification or any other similar reports.
[12.15.4.7 NMAC - N, 01/30/2004; A, 08/31/09]

12.15.4.8 [~~DEBT-TO-INCOME RATIOS:~~ ~~Pursuant to Subsection H of Section 58-21A-5 NMSA 1978, there shall be a rebuttable presumption that a creditor made a loan with due regard for repayment ability based on debt-to-income ratios if, at the time the loan was consummated, the creditor determined, based on a review of relevant financial records, that the borrower's total monthly debts, including amounts owed under the loan, did not exceed fifty percent (50%) of the borrower's monthly gross income.~~] **REASONABLE ABILITY TO REPAY:** The documentation of "reasonable ability to repay", in Chapter 122 Session Law Section 56(C), will depend upon the totality of facts and circumstances relating to a specific residential mortgage loan transaction and the borrower's financial condition and circumstances. While the documentation of certain residential mortgage loan transactions may clearly demonstrate the borrower's reasonable ability to repay, others may require closer scrutiny to determine whether the documentation for a particular residential mortgage loan transaction sufficiently demonstrates ability to repay. The "reasonable ability to repay" standard shall be demonstrated through reasonably reliable documentation.
[12.15.4.8 NMAC - N, 01/30/2004; A, 08/31/09]

12.15.4.9 [~~RESIDUAL INCOME GUIDELINES:~~ ~~Pursuant to Subsection H of Section 58-21A-5 NMSA 1978, there shall be a rebuttable presumption that a creditor made a loan with due regard for repayment ability based on residual income guidelines if, at the time the loan was consummated, the creditor determined, based on a review of relevant financial records, that the borrower's net residual income after total monthly debts, including amounts owed under the loan, was at least seven hundred and fifty dollars ($750) or two hundred dollars ($200) per family household member, whichever is greater.~~] [RESERVED]
[12.15.4.9 NMAC - N, 01/30/2004; Repealed, 08/31/09]

NEW MEXICO REGULATION AND LICENSING DEPARTMENT
FINANCIAL INSTITUTIONS DIVISION

This is an amendment to 12.19.1 NMAC Sections 2, 3, 6 and 7, effective 08/31/2009.

TITLE 12 TRADE, COMMERCE AND BANKING
CHAPTER 19 [~~MORTGAGE COMPANIES~~] MORTGAGE LENDING
PART 1 GENERAL PROVISIONS

12.19.1.2 SCOPE: All [~~mortgage loan companies and loan brokers licensed or registered~~] mortgage loan companies and mortgage loan originators licensed by the state of New Mexico.
[5/5/86, 9/30/97 - Rn, 12 NMAC 19.1.2, 12/15/08; A, 08/31/09]

12.19.1.3 STATUTORY AUTHORITY: Mortgage Loan Company Act, Section 58-21-9 NMSA 1978 and New Mexico Mortgage Loan Originator Licensing Act, Chapter 122 Section 19(B) Session Law 2009.
[9/30/97 - Rn, 12 NMAC 19.1.3, 12/15/08; A, 08/31/09]

12.19.1.6 OBJECTIVE: The objective of this part is to effectuate the purposes of the [~~Mortgage Loan Company and Loan Broker Act~~] Mortgage Loan Company Act, Section 58-21-1 NMSA 1978 et seq., and the New Mexico Mortgage Loan Originator Licensing Act, Chapter 122 Session Law 2009 and to clarify [~~its~~] their meaning.
[5/5/86, 9/30/97 - Rn, 12 NMAC 19.1.6 & A, 12/15/08; A, 08/31/09]

12.19.1.7 DEFINITIONS:

A. "Affiliate" means a person who, directly or indirectly, through one or more intermediaries, controls or is controlled by or is under common control with another person.

B. "Branch office" means any location, including a divisional office, separate from the principal place of business of the mortgage loan company that is identified by any means to the public or customers as a location at which the licensee holds itself out as a mortgage loan company.

C. "Clerical or support duties" may include, subsequent to the receipt of an application:

(1) the receipt, collection, distributionand analysis of information common for the processing or underwriting of a residential mortgage loan; and

(2) communicating with a consumer to obtain the information necessary for the processing or underwriting of a loan, to the extent that such communication does not include offering or negotiating loan rates or terms or counseling consumers about residential mortgage loan rates or terms;

[~~B.~~]D. "Closing agent" means a person, including a title insurance agent or title insurance company, that acts in the normal course of business in a fiduciary capacity as a disinterested third party for the seller and buyer of real property for the purpose of consummating a sale of real property, including the performance of the following functions:

(1) preparation of deeds, mortgages, promissory notes, deeds of trust, real estate contracts, assignments or other documents incidental to the sale as permitted by law;

(2) calculations and disbursements of prorated taxes, insurance premiums, utility bills and other charges incidental to the sale;

(3) preparation of sellers' and buyers' closing statements;

(4) supervision of signing of documents;

(5) collection and disbursement of down payments, commissions of real estate licensees, fees and other charges pursuant to a sales agreement; and

(6) recordation of documents;

E. "Depository institution" has the same meaning as the definition of depository institution in Section 3 of the Federal Deposit Insurance Act and includes any credit union.

[~~C.~~]F. "Division" means the financial institutions division of the regulation and licensing department.

[~~D.~~]G. "Director" means the director of the financial institutions division of the regulation and licensing department.

[~~E. "Dwelling" means a residential structure, including a home, individual condominium unit, manufactured home or modular home, that contains one to~~

~~four units and is permanently attached to real property.]~~

H. "Dwelling" means a residential structure that contains one to four units whether or not that structure is attached to real property. **"Dwelling"** includes an individual condominium unit, an individual cooperative unit, a mobile home and a trailer if used as a residence.

I. "Federal banking agencies" means the board of governors of the federal reserve system, the comptroller of the currency, the director of the office of thrift supervision, the national credit union administration and the federal deposit insurance corporation.

J. "Immediate family member" means a spouse, child, sibling, parent, grandparent or grandchild, and **"immediate family member"** includes a stepparent, a stepchild, a stepsibling and an adoptive relationship.

K. "Individual" means a natural person.

[~~F.~~]L. "Lender" means a person or government agency making a mortgage loan.

M. "License" means a license issued pursuant to Section 6 of the New Mexico Mortgage Loan Originator Licensing Act.

[~~G. "Loan broker" means any person who acts as a finder or agent of a lender or borrower of money for the purpose of procuring a mortgage loan, or both.~~]

N. "Loan processor or underwriter" means an individual who performs clerical or support duties as an employee at the direction of and subject to the supervision and instruction of a person licensed, or exempt from licensing, pursuant to the Mortgage Loan Company Act.

[~~H. "Mortgage loan" means a loan secured by a dwelling permanently affixed to real property.~~]

O. "Mortgage loan" means any loan primarily for personal, family or household use that is secured by a mortgage, deed of trust or other equivalent consensual security interest on a dwelling or residential real estate upon which is constructed or intended to be constructed a dwelling as so defined.

[~~I. "Mortgage loan company" means a person who, directly or indirectly:~~

~~(1) holds himself out as being able to serve as an agent for any person in an attempt to obtain a mortgage loan;~~

~~(2) holds himself out as being able to serve as an agent for a person who makes mortgage loans; or~~

~~(3) holds himself out as being able to make mortgage loans.~~]

P. "Mortgage loan company" means any person who, for compensation or gain, or in the expectation of compensation or gain, either directly or indirectly:

(1) accepts an application for a mortgage loan; negotiates terms for a mortgage loan; or solicits, processes, originates, brokers or makes mortgage loans for others;

(2) offers to:

(a) accept an application for a mortgage loan;

(b) negotiate terms for a mortgage loan; or

(c) solicit, process, originate, broker or make mortgage loans for others; or

(3) closes mortgage loans that may be in the mortgage loan company's own name with funds provided by others and that are assigned to the mortgage lenders providing the funding of such loans;

Q. "Mortgage loan originator" means an individual who for compensation or gain or in the expectation of compensation or gain takes a residential mortgage loan application or offers or negotiates terms of a residential mortgage loan. "Mortgage loan originator" does not include:

(1) an individual engaged solely as a loan processor or underwriter except as otherwise provided in Subsection I of this section;

(2) a person that only performs real estate brokerage activities and is licensed or registered in accordance with New Mexico law, unless the person is compensated by a lender, a mortgage loan company or other mortgage loan originator or by any agent of such lender, mortgage loan company or other mortgage loan originator; and

(3) a person solely involved in extensions of credit relating to timeshare plans, as that term is defined in Section 101(53D) of Title 11 of the United States Code.

R. "Nationwide mortgage licensing system and registry" means a mortgage licensing system developed and maintained by the conference of state bank supervisors and the American association of residential mortgage regulators for the licensing and registration of licensed mortgage loan originators.

[~~J.~~]S. "Net loan funds" means the mortgage loan amounts specified in the note and mortgage less lender-retained fees, as specified in the lender's instruction to the closing agent.

T. "Nontraditional mortgage product" means any mortgage product other than a thirty-year fixed rate mortgage.

U. "Person" means a natural person, corporation, company, limited liability company, partnership or association.

V. "Qualified manager" means an individual, designated by a mortgage loan company, responsible for the activities of the licensed mortgage loan company's office, divisional office or branch office in conducting the business of that mortgage loan company's office, divisional office or branch office and who meets requirements as specified by the director.

W. "Real estate brokerage activity" means any activity that involves offering or providing real estate brokerage services to the public, including:

(1) acting as a real estate agent or real estate broker for a buyer, seller, lessor or lessee of real property;

(2) bringing together parties interested in the sale, purchase, lease, rental or exchange of real property;

(3) negotiating, on behalf of any party, any portion of a contract relating to the sale, purchase, lease, rental or exchange of real property, other than in connection with providing financing with respect to any such transaction;

(4) engaging in any activity for which a person engaged in the activity is required to be registered or licensed as a real estate agent or real estate broker pursuant to any applicable law; and

(5) offering to engage in any activity or to act in any capacity described in Paragraphs (1) through (4) of this subsection.

X. "Registered mortgage loan originator" means any individual who meets the definition of mortgage loan originator, is registered with, and maintains a unique identifier through, the nationwide mortgage licensing system and registryand is an employee of:

(1) a depository institution;

(2) a subsidiary that is:

(a) owned and controlled by a depository institution; and

(b) regulated by a federal banking agency; or

(3) an institution regulated by the farm credit administration.

Y. "Residential mortgage loan" means any loan primarily for personal, family or household use that is secured by a mortgage, deed of trust or other equivalent consensual security interest on a dwelling or on residential real estate upon which is constructed or is intended to be constructed a dwelling as so defined.

Z. "Residential real estate" means any real property located in New Mexico upon which is constructed or intended to be constructed a dwelling.

AA. "Servicer" means a person that collects or receives payments, including principal, interest and trust items such as hazard insurance, property taxes and other amounts due, on behalf of a note holder or investor in accordance with the terms of a residential mortgage loan, and includes working with a borrower on behalf of a note holder or investor, when the borrower

is in financial hardship or default, to modify either temporarily or permanently the terms of an existing residential mortgage loan.

BB. "Unique identifier" means a number or other identifier assigned by protocols established by the nationwide mortgage licensing system and registry.

[K.]CC. The phrase **"any action or proceeding, civil or criminal, judicial or administrative, completed or in progress"**, as used in Section 58-21-4[(F)](G) NMSA 1978, shall be exclusive of divorce proceedings and misdemeanor traffic citations.

[5/5/86, 9/30/97 - Rn, 12 NMAC 19.1.7 & A, 12/15/08; A, 08/31/09]

NEW MEXICO REGULATION AND LICENSING DEPARTMENT
FINANCIAL INSTITUTIONS DIVISION

This is an amendment to 12.19.8 NMAC Sections 2, 3, 6, 7, 8, 9, and 10 and the addition of new Sections 11, 12, 13, 14 and 15, effective 08/31/2009.

TITLE 12 TRADE, COMMERCE AND BANKING
CHAPTER 19 [~~MORTGAGE COMPANIES~~] MORTGAGE LENDING
PART 8 MORTGAGE LOAN COMPANY [~~AND LOAN BROKER~~] REQUIREMENTS

12.19.8.2 SCOPE: All mortgage loan companies [~~and loan brokers~~] licensed [~~or registered~~] by the state of New Mexico.

[12.19.8.2 NMAC - Rp, 12 NMAC 19.2.8.2, 12/15/08; A, 08/31/09]

12.19.8.3 STATUTORY AUTHORITY: Mortgage Loan Company Act, Section 58-21-9 NMSA 1978.

[12.19.8.3 NMAC - Rp, 12 NMAC 19.2.8.3, 12/15/08; A, 08/31/09]

12.19.8.6 OBJECTIVE: The objective of this part is to effectuate the purposes of the Mortgage Loan Company [~~and Loan Broker~~] Act.

[12.19.8.6 NMAC - Rp, 12 NMAC 19.2.8.6, 12/15/08; A, 08/31/09]

12.19.8.7 DEFINITIONS:

A. "Applicant" means a person who has applied for [~~registration~~] a license pursuant to the provisions of the Mortgage Loan Company [~~and Loan Broker~~] Act, and includes all directors, officers, employees, trustees and owners of such person.

B. "Independent contractor" means any person who originates, processes or underwrites mortgage loans and is not a W-2 employee of a [~~registered broker~~] licensed mortgage loan company.

[D.] C. [~~"Registrant"~~] "Licensee" means a person who is [~~registered~~] licensed pursuant to the provisions of the act, and includes all directors, officers, employees, trustees and owners of such person.

[C.] D. "Person who controls or is controlled", with respect to Section 58-21-2(A) NMSA 1978, means a person who is a director or executive officer of a business or organization, who directly or indirectly, or acting in concert with one or more other persons or entities, owns, controls or holds power to vote, or holds proxies representing ten percent (10%) or more of the voting shares or rights of any entity, or the spouse of such person.

E. "Reasonably reliable documentation" means any documentation that is required by a mortgage loan company to satisfy the requirements of a loan product that meets the borrower's requested terms and qualifications, documents the source of repayment and includes verifiable written documentation obtained from the borrower or a third party. Reasonably reliable documentation may include but may not be limited to verbal verifications.

[12.19.8.7 NMAC - Rp, 12 NMAC 19.2.8.7, 12/15/08; A, 08/31/09]

12.19.8.8 APPLICANT AND [~~REGISTRANT~~] LICENSEE REQUIREMENTS:

A. Application for [~~registration~~] licensure: In addition to the information required by Section 58-21-4 of the act, each applicant for issuance or renewal of a [~~registration certificate~~] license shall be subject to the following requirements:

(1) applications for [~~registration~~] license or renewal of a [~~registration~~] license shall be made using forms provided by the director;

(2) if the application is for renewal of a [~~registration~~] license, the applicant shall specify any changes in the location or name of the business within the last 12 months and list the names and addresses of any person having acquired an interest in the business within the last 12 months; this update of information does not relieve the [~~registrant~~] licenseeof updating any such information under Section 58-21-11 NMSA 1978;

(3) the current [~~registration certificate~~] license issued pursuant to the act shall be prominently displayed at the principal office of the [~~registrant~~] licensee; a branch [~~registration certificate~~] licensee shall be prominently displayed at each branch office of the [~~registrant~~] licensee [~~in New Mexico~~];

(4) independent contractors, prior to originating mortgage loans, shall file an application with the director and obtain a [~~registration certificate~~] license under the Mortgage Loan Company [~~and Loan Broker~~] Act (58-21-1) NMSA 1978.

B. [~~Registrants~~] Licensees shall keep the following records and make them available upon examination or investigation:

(1) documents related to the settlement of a residential mortgage loan which includes, but are not limited to:

(a) mortgage loan transaction documents: all loan applications, written or electronic, loan transmittal summary, credit report, appraisal, all verifications (mortgage, rent, deposits, employment, income), lender loan approval, clear to close and interest rate lock-in confirmation, title commitment, survey and sales contract (if loan is a purchase);

(b) rate sheet(s) used in the determination of the information used on the initial good faith estimate and loan application and any subsequent good faith estimate and loan application done prior to interest rate lock-in;

(c) rate sheet(s) used for the determination of the interest rate that was locked-in with the lender for the purpose of settlement and funding the loan;

(d) all disclosures required by the Real Estate Settlement Procedures Act, Truth in Lending Act (Regulation Z), the Equal Credit Opportunity Act [~~and~~], the Patriot Act and the Mortgage Loan Company Act;

(e) disclosures that include: borrower's signature, certification and authorization, fair credit reporting, affidavit of occupancy, insurance anti-coercion statement, mortgage loan agreement, privacy policy, loan comparison for adjustable rate mortgages, credit score information;

(f) title documents: note, mortgage or deed of trust (including all riders for the note and mortgage or deed of trust), final signed truth-in-lending disclosure, lender's closing instructions to the title company, closing disbursement sheet and copies of issued checks or direct deposits, initial escrow account statement and right of rescission;

(2) all evidence of payment of commissions, brokers' fees or other forms of compensation for services rendered in connection with a mortgage loan transaction;

(3) all books, records, canceled checks pertaining to, but are not limited to, the mortgage loan transactions and payment of fees; books and records shall include cash receipts and disbursements journals, to be posted daily, and a general ledger, to be posted monthly;

(4) the books of account shall include a funded residential mortgage loan journal showing an entry for each mortgage

loan transaction completed;

(5) records covered by 12.19.8 NMAC include electronic records.

C. [~~Registrants'~~] Licensees' accounts.

(1) Trust accounts: All funds belonging to third party settlement service providers (e.g., appraisal services, credit reporting agencies), borrowers or sellers, shall, upon receipt thereof, be deposited into the [~~registrant's~~] licensee's trust account that is set up exclusively for the deposit and disbursement of third party settlement service fees and the borrowers or sellers funds. The trust account shall be established with a depository institution the accounts of which are insured by the federal deposit insurance corporation or the national credit union administration. Deposited funds shall remain in the trust account until disbursed to the third party settlement service providers, used at settlement for the borrowers benefit or returned to the rightful borrowers or sellers. If the trust account is interest-bearing, all interest shall be distributed to the appropriate parties, on a pro rata basis, at the time trust funds are disbursed or returned. All funds received by the [~~registrant~~] licensee must be disbursed within 30 days of the settlement of the residential mortgage loan.

(2) If a [~~registrant~~] licensee requires a deposit in connection with an application for a mortgage loan, there must be an agreement in writing between [~~applicant~~] consumer and [~~registrant~~] licensee, setting forth the disposition of the deposit, whether the loan is finally consummated or not.

(3) Deposit accounts: All deposit accounts maintained by a [~~registrant~~] licensee shall be reconciled within ten (10) business days after receipt of statements; "deposit accounts" includes all accounts maintained with depository institutions.

[12.19.8.8 NMAC - Rp, 12 NMAC 19.2.8.8.1, 5 & 6, 12/15/08; A, 08/31/09]

12.19.8.9 GOOD BUSINESS REPUTATION: Pursuant to Section 58-21-8(A) of the act, a [~~registrant~~] licensee or applicant may be deemed to lack a good business reputation if the director finds that the [~~registrant~~] licensee or applicant has done or is doing any of the following, which includes, but is not limited to:

A. repeatedly issues worthless checks;

B. has outstanding unsatisfied judgments;

C. repeatedly fails to meet obligations when due;

D. fails to pay the examination fee provided by Section 58-21-12 NMSA 1978;

E. allows [~~unregistered~~] unlicensed independent contractors to originate mortgage loans [~~using the registrant's certificate~~].

[12.19.8.9 NMAC - Rp, 12 NMAC 19.2.8.8.7, 12/15/08; A, 08/31/09]

12.19.8.10 HEARING PROCEDURES: Hearings requested, pursuant to Section 58-21-14 of the act, by applicants or [~~registrants~~] licensees shall be conducted under the following procedures.

A. Hearings shall be conducted pursuant to Section 12-8-10 NMSA 1978 and Section 12-8-11 NMSA 1978 of the Administrative Procedures Act (12-8-1) NMSA 1978 and any future amendments to this section.

B. Hearings shall be conducted in Santa Fe county, or upon agreement by the director and an applicant or [~~registrant~~] licensee, a hearing may be conducted in a county other than Santa Fe county or the county in which the apparent violation or violations occurred.

C. All hearings shall be conducted by the director or by a hearing officer designated by the director. A hearing officer shall, within 30 days following the hearing, submit to the director a report setting forth his findings of fact and conclusions of law.

D. All hearings shall be open to the public. In cases in which the reputation of an applicant or [~~registrant~~] licensee may be damaged or, for good cause shown, the director or hearing officer may hold a closed hearing and must state the reasons for this decision in the record.

E. A complete record shall be made of all evidence and testimony received during the course of any hearing.

F. Within sixty (60) days after the hearing, the director shall serve upon the applicant or [~~registrant~~] licensee a copy of the final written order.

[12.19.8.10 NMAC - Rp, 12 NMAC 19.2.8.8.8, 12/15/08; A, 08/31/09]

12.19.8.11 FEES: A mortgage loan company shall pay the following fees to maintain a valid mortgage loan company or branch license. These fees are non-refundable. These fees are in addition to any fees established and charged by the nationwide mortgage licensing system and registry.

A. Main office:

(1) application fee: $500.00;

(2) license fee: $500.00;

(3) supervisory fee: $500.00;

(4) annual license renewal fee: $500.00;

(5) annual supervisory renewal fee: $500.00;

(6) reinstatement fe: $250.00;

(7) amendment fes: $50.00.

B. Branch office:

(1) license fee: $500.00;

(2) annual license renewal fee: $500.00;

(3) reinstatement fee: $250.00;

(4) branch amendment fees: $50.00.

[12.19.8.11 NMAC - N, 08/31/09]

12.19.8.12 DISCLOSURES:

A. Mortgage loan companies shall provide rate lock disclosures to and enter into signed lock-in agreements with a borrower(s). The mortgage loan company shall use a rate lock disclosure form of their choosing. The rate lock disclosure shall include the following information: (1) a rate float option, (2) the lock-in loan interest rate, (3) loan pricing for the lock-in interest rate, (4) loan terms, (5) loan lock-in period and (6) any fees required for an extension of the lock-in period. For the purposes of act, the term "pricing" means the credit or charge to the borrower(s) for the loan interest rate.

B. At least two (2) days prior to closing, a mortgage loan company shall provide to the borrower(s) the following federal disclosures specific to the mortgage loan the borrower(s) is receiving: (1) a good faith estimate and (2) a truth in lending statement. These documents shall be used to comply with Chapter 122 Session Law 2009 Section 52 (D) and (E). For the purposes of the act, the yield spread premium or discount points received by the mortgage loan company shall be disclosed as a dollar amount on all Good Faith Estimates.

[12.19.8.12 NMAC - N, 08/31/09]

12.19.8.13 QUALIFIED MANAGER:

A. A qualified manager shall provide the director with the following documentation of his or her lending experience for verification purposes:

(1) income tax returns;

(2) W-2 and/or 1099 forms.

B. Documentation may also include previous business licenses and other state mortgage licenses.

[12.19.8.13 NMAC - N, 08/31/09]

12.19.8.14 SURETY BOND: Every surety bond shall provide that no suit or claim shall be maintained to enforce any liability on the bond unless brought within six years after the act upon which the suit or claim is based.

[12.19.8.14 NMAC - N, 08/31/09]

12.19.8.15 REASONABLE ABILITY TO REPAY: The documentation of "reasonable ability to repay", in Chapter 122 Session Law 2009 Section 32(N), will depend upon the totality of facts and circumstances relating to a specific residential mortgage loan transaction and the borrower's financial condition and circumstances. While the documentation of certain residential mortgage loan transactions may clearly demonstrate the

borrower's reasonable ability to repay, others may require closer scrutiny to determine whether the documentation for a particular residential mortgage loan transaction sufficiently demonstrates ability to repay. The "reasonable ability to repay" standard shall be demonstrated through reasonably reliable documentation.
[12.19.8.15 NMAC - N, 08/31/09]

End of Adopted Rules Section

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Other Material Related to Administrative Law

NEW MEXICO COMMISSION OF PUBLIC RECORDS

HISTORICAL RECORDS ADVISORY BOARD

Commission of Public Records
New Mexico State Records Center & Archives
1205 Camino Carlos Rey
Santa Fe, New Mexico 87507

NOTICE OF REGULAR MEETING

The New Mexico Historical Records Advisory Board has scheduled a regular meeting for Friday, Sept. 18, 2009 from 9:00 a.m. to 12:00 noon. The meeting will be held in the Commission Room of the New Mexico State Records Center & Archives, which is an accessible facility, at 1209 Camino Carlos Rey, Santa Fe, NM, 87507. If you are an individual with a disability who is in need of a reader, amplifier, qualified sign language interpreter, or any form of auxiliary aid or service to attend or participate in the meeting, please contact Randy Forrester at 505-476-7936 of the State Records Center and Archives at least one week prior to the meeting. Public documents, including the agenda and minutes will be available 24 hours before the meeting.

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
Issue Number 9	May 1	May 14
Issue Number 10	May 15	May 29
Issue Number 11	June 1	June 15
Issue Number 12	June 16	June 30
Issue Number 13	July 1	July 16
Issue Number 14	July 17	July 31
Issue Number 15	August 3	August 14
Issue Number 16	August 17	August 31
Issue Number 17	September 1	September 15
Issue Number 18	September 16	September 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.