Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD-IPP 81-8, Limiting Assistance to 36 Months After Arrival into U.S. to Refugees (ISD Categories 19 and 49), 4/10/1981.
ISD-IPP 82-7, Limiting Refugee Assistance to 18 Months After Refugee's Arrival into U.S., 3/15/1982.
ISD 281.0000, Refugee Eligibility Conditions, 6/29/1982.
ISD FA 610, Refugee Resettlement Program, 2/11/1988.
ISD FA 610, Refugee Resettlement Program, 7/2/1990.

History of Repealed Material:
8 NMAC 3.RRP, Refugee Resettlement Program - Repealed, 07/01/1997.
8.119.110 NMAC - General Operating Policies Applications (filed 3/6/2001) Repealed, effective 7/1/2024.

Other: 8.119.110 NMAC - General Operating Policies Applications (filed 3/6/2001) Replaced by 8.119.110 NMAC - General Operating Policies Applications, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 119 REFUGEE RESETTLEMENT PROGRAM
PART 410 RECIPIENT POLICIES -GENERAL RECIPIENT REQUIREMENTS

8.119.410.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.119.410.1 NMAC - Rp 8.119.410.1 NMAC, 7/1/2024]

8.119.410.2 SCOPE: The rule applies to the general public.
[8.119.410.2 NMAC - Rp 8.119.410.2 NMAC, 7/1/2024]

8.119.410.3 STATUTORY AUTHORITY:

A. The refugee resettlement program (RRP) is authorized under Title IV of the Immigration and Nationality Act of 1980. The act designates the federal department of health and human services (DHHS) as the federal administering agency. RRP regulations are issued by DHHS in the Code of Federal Regulations, Title 45, Part 400, which is supplemented by administrative and program instructions issued by the federal department from time to time.

B. In accordance with authority granted to the health care authority by Subsection J of Section 27-1-3 NMSA 1978, and pursuant to executive order No. 80-62, dated 10/01/1981, the governor of the state of New Mexico has designated the health care authority (HCA) as the single state agency responsible for administering the program in New Mexico.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.119.410.3 NMAC - Rp 8.119.410.3 NMAC, 7/1/2024]

8.119.410.4 DURATION: Permanent.
[8.119.410.4 NMAC - Rp 8.119.410.4 NMAC, 7/1/2024]

8.119.410.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.119.410.5 NMAC - Rp 8.119.410.5 NMAC, 7/1/2024]

8.119.410.6 OBJECTIVE: The objective of the RRP is to assist refugees to become self-sufficient by providing a program of financial and medical assistance while, supportive services are provided, to ensure the effective resettlement of refugees in the state of New Mexico through programs designed to assist with integration, promotion of economic self-sufficiency, and protecting refugees and communities from infectious diseases and other health related issues. The HCA has agreed to administer this program subject to the receipt of federal funds. Under the RRP, sponsors(s) and VOLAGs work closely with the federal government to coordinate support services authorized under the program. The RRP includes the provision of refugee cash assistance (RCA), refugee medical assistance (RMA), refugee social services (RSS) and additional support services funded by the office of refugee resettlement (ORR).
[8.119.410.6 NMAC - Rp 8.119.410.6 NMAC, 7/1/2024]

8.119.410.7 DEFINITIONS: [**RESERVED**]
[8.119.410.7 NMAC - Rp 8.119.410.7 NMAC, 7/1/2024]

8.119.410.8 GENERAL RECIPIENT REQUIREMENTS:

A. Citizenship

(1) To be eligible for inclusion in the RCA benefit group, the applicant must be classified as a "refugee."

(2) To be eligible for inclusion in the RRP benefit group the individual must provide proof, in the form of documentation issued by USCIS, of one of the following statuses under the INA as a condition of eligibility:

(a) paroled as a refugee or asylee under section 212(d)(5) of INA; or

(b) admitted as a refugee under section 207 of the INA; or

(c) granted asylum under section 208 of the INA; or

(d) Cuban and Haitian entrants including:

(i) any individual granted parole status as a Cuban/Haitian entrant (status pending) or granted any other special status subsequently established under the immigration laws for nationals of Cuba or Haiti, regardless of the status of the individual at the time assistance or services are provided; and

(ii)

any other national of Cuba or Haiti who was paroled into the U.S. and has not acquired any other status under the INA; is the subject of exclusion or deportation proceedings under the INA; or has an application for asylum pending with the INS; and with respect to whom a final, non-appealable, and legally enforceable order of deportation or exclusion has not been entered; or

(e) certain Amerasians from Vietnam who are admitted to the U.S. as immigrants pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as contained in section 101(e) of the 9th proviso under Migration and Refugee Assistance in title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Acts 1989 (Public Law 100-461 as amended)); or

(f) admitted for permanent residence, provided the individual previously held one of the statuses identified above.

(3) An applicant for asylum is not eligible for assistance under title IV of the INA unless otherwise provided by federal law.

B. Time limits:

(1) Eligibility for RCA is limited to 12 months from the date of entry, date of asylum, or date deportation was withheld.

(2) For refugee assistance cases involving U.S. born children, the eligibility for RCA for the child expires when the refugee parent who last arrived in the U.S. has been in the country for eight months.

C. General eligibility requirements:

(1) RCA eligibility is limited to those who are ineligible for TANF. The benefit groups' eligibility for TANF must be determined before determining eligibility for RCA.

(2) An individual who is enrolled full-time in an institution of higher education will be ineligible to participate in the RCA program except where such enrollment has been approved as part of the individual's individual employability plan (IEP) and in which the enrollment will last for a period of less than one year.

(a) An individual is considered to be enrolled in an institution of higher education, if the individual is enrolled in a business, technical, trade or vocational school, that normally requires a high school diploma or equivalency certificate for enrollment in the curriculum or if the individual is enrolled in a regular curriculum at a college or university that offers degree programs regardless of whether a high school diploma is required.

(b) The enrollment status of a student shall begin on the first day of the school term. Such enrollment shall be deemed to continue through normal periods of class attendance, vacation and semester breaks. Enrollment status shall terminate when the student graduates, is expelled, does not re-enroll or is suspended for a period in excess of 30 calendar days.

(3) A refugee must provide the name of the resettlement agency which was responsible for their resettlement.

(4) Possession of a social security number is not a requirement of eligibility for RCA.

[8.119.410.8 NMAC - Rp 8.119.410.8 NMAC, 7/1/2024]

8.119.410.9 RESIDENCY: To be eligible of assistance under this program, the refugee(s) must be physically present in New Mexico on the date of application or final determination of the eligibility and demonstrate intent to remain in the state.

[8.119.410.9 NMAC - Rp 8.119.410.9 NMAC, 7/1/2024]

8.119.410.10 NON-CONCURRENT RECEIPT OF ASSISTANCE: To be eligible for inclusion in the RCA benefit group, the refugee(s) may not be receiving cash assistance under any other HCA program of cash assistance or SSI.

[8.119.410.10 NMAC - Rp 8.119.410.10 NMAC, 7/1/2024]

8.119.410.11 EMPLOYMENT TRAINING AND WORK REGISTRATION:

A. Requirement:

(1) All employable refugees who receive RCA, and all employable members of the assistance group of which they are part, must register for employment with an appropriate agency providing employment services or the department of workforce solutions (NMDWS), and must accept an employment or training opportunity from any source which is determined appropriate for that refugee by HCA.

(2) Refugees may register for employment services with the contracted provider of the RSS program. As a condition of eligibility each employable member of the benefit group must complete, and comply with, an IEP with the contracted RSS provider. Failure to comply with the IEP may result in disqualification from RCA.

(3) As a condition for receipt of RCA a refugee who is not otherwise exempt, or does not demonstrate good cause, must:

(a) go to job interviews that are arranged by HCA, the contracted RSS provider, or the resettlement agency which was responsible for the initial resettlement of the refugee;

(b) accept at any time an offer of employment, determined to be appropriate by HCA, the contracted RSS provider, or the resettlement agency which was responsible for the initial resettlement of the refugee; and

(c) participate in any employability services program which provides job or language training in the area in which the refugee resides, as deemed to be appropriate by HCA, the contracted RSS provider, or the resettlement agency which was responsible for the initial resettlement of the refugee.

(4) The ISD

office shall contact the local sponsor or resettlement agency to determine if the refugee has refused, within 30 days of application, an offer of employment or has voluntarily quit a job without good cause.

B. Appropriateness of placement:

(1) Employment placements must be within the scope of the individuals IEP; the plan may be modified to reflect changes in services or employment conditions.

(2) Services and employment must be related to the capability of the individual to perform the task on a regular basis. Claims, by the individual, of adverse effect on physical or mental health must be based on medical verification from a physician or licensed or certified psychologist;

(3) The total daily commuting time to and from home to the service or employment site must not normally exceed 2 hours, not including the transporting of a child to and from a child care facility, unless a longer commuting distance or time is generally accepted in the community, in which case the round trip commuting time must not exceed the generally accepted community standards.

(4) When childcare is required, the care must meet the standards normally required by the state for NMW recipients.

(5) The service or employment site to which the individual is assigned must not be in violation of applicable federal, state, or local health and safety standards.

(6) Assignments may not be made that are discriminatory in terms of age, sex, race, creed, color, or national origin.

(7) Appropriate employment placements may be temporary, permanent, full-time, part-time, or seasonal employment if such employment meets the other standards of this section.

(8) The service or work site must comply with all applicable federal, state, and local labor laws and regulations.

(9) The wage shall meet or exceed the federal or state minimum wage, whichever is applicable, or if such laws are not applicable, the wage shall not be substantially less favorable than the wage normally paid for similar work in that labor market.

(10) The daily hours of work and the weekly hours of work shall not exceed those customary to the occupation.

(11) No individual may be required to accept employment if:

(a) the position offered is vacant due to a strike, lockout, or other bona fide labor dispute; or

(b) the individual would be required to work for an employer contrary to the conditions of their existing membership in the union governing that occupation; however, employment not governed by the rules of a union in which they have membership may be deemed appropriate.

(12) In addition to meeting the other criteria of this paragraph, the quality of training must meet local employers' requirements so that the individual will be in a competitive position within the labor market; the training must be likely to lead to employment which will meet the appropriate work criteria.

(13) If an individual is a professional in need of professional refresher training and other recertification services in order to qualify to practice their profession in the U.S., the training may consist of full-time attendance in a college or professional training program, provided that such training:

(a) is approved as a part of the individual's employability plan by the state agency;

(b) does not exceed one year's duration (including any time enrolled in such program in the U.S. prior to the refugee's application for assistance);

(c) is specifically intended to assist the professional in becoming relicensed in their profession; and if completed,

(d) can realistically be expected to result in such relicensing; and

(e) may only be made available to individuals who are employed.

C. Job offers: A job offer, if determined appropriate under the requirements of this section, must be accepted by the refugee without regard to whether such job would interrupt a program of services planned or in progress.

D. Failure or refusal to carry out job search or to accept employability services of employment:

(1) Voluntary registrants: Voluntary registrants are recipients of refugee cash assistance who are exempt from registration for training and employment services. When a voluntary registrant fails or refuses to participate in appropriate employability services, to carry out job search, or to accept an appropriate offer of employment, the state agency, may remove the individual from the registry for up to 90 days from the date of determination that such failure or refusal has occurred, but the individual's cash assistance may not be affected.

(2) Mandatory registrants: A mandatory registrant - i.e., an employable recipient of refugee cash assistance who is not exempt from registration, who has failed or refused without good cause to meet the requirements or has voluntarily quit a job, will be disqualified as outlined in Subsection G below.

E. Work requirements - exemptions:

(1) An individual is considered employable unless they are a minor dependent child. A minor unmarried parent, acting as a head of household, is not considered to be a "dependent child," and is subject to participation as an adult.

(2) Inability

to communicate in English does not exempt a refugee from registration for employment services, participation in employability service programs, carrying out job search, and acceptance of appropriate offers of employment.

F. Refusal to accept or termination of employment:

(1) Applicants: An applicant is not eligible if 30 consecutive calendar days immediately prior to the receipt of aid, they have voluntarily quit a job without good cause, refused to apply for, or accept an appropriate offer of employment, as determined by HCA. The dependent family of such an ineligible applicant may, however, remain eligible for RCA.

(2) Recipients: An employable recipient must not have refused, without good cause, to go to a job interview which is arranged by the RSS provider or have, without good cause, voluntarily quit a job, or have refused to apply for or accept an appropriate offer of employment.

(3) Job search: An employable recipient shall attend job interviews, register for employment and comply with the terms of their IEP. Termination of employment, by a recipient, shall only be with good cause. Refusal by a recipient to fulfill the job search requirement, or termination of employment without good cause is noncompliance.

(4) Good cause: Determination of good cause for noncompliance is made by the HCA case worker and is based on the following documented circumstances:

(a) court required appearance or incarceration;

(b) an individual is already engaged in employment consistent with the work plan;

(c) a pregnant woman, starting with the 4th month of pregnancy, provided that the pregnancy and the expected date of birth have been medically verified;

(d) medically verified illness of the participant or the participant's infant child. An infant child is defined as a child under 12 months of age.

(5) The refugee must participate in the employment program once good cause for noncompliance has been remedied.

G. Disqualification: Disqualification will follow the procedures set forth below.

(1) Cause for disqualification: A refugee recipient, who refuses an offer of employment, voluntarily quits employment without good cause, as determined by HCA, or fails to comply with their IEP is eligible for disqualification.

(2) The refugee shall be provided with a notice of adverse action not less than 13 days prior to the termination date. Additionally, the refugee's sponsor or resettlement agency will be notified of the action taken. The notice of adverse action will follow the policy outlined in 8.100.180.10 NMAC. The notice may include more than one instance of noncompliance or there may be separate notices for each instance of noncompliance. Each instance of noncompliance must be either resolved in a timely manner or a disqualification may occur.

(3) If the refugee regains compliance within the 30 day period after the initial date for noncompliance, assistance shall be continued without interruption so long as the refugee continues to meet the requirements of continued assistance.

(4) A disqualification consists of termination of assistance beginning 30 days after the date of the noncompliance. An employable RRP recipient is ineligible for benefits for the following periods when assistance is terminated due to noncompliance;

(a) for three payment months for the first occurrence.

(b) for six payment months for the second and subsequent occurrences.

[8.119.410.11 NMAC - Rp 8.119.410.11 NMAC, 7/1/2024]

History of 8.119.410 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD-IPP 81-8, Limiting Assistance to 36 Months After Arrival into U.S. to Refugees (ISD Catagories 19 and 49), 4/10/1981.
ISD-IPP 82-7, Limiting Refugee Assistance to 18 Months After Refugee's Arrival into U.S., 3/15/1982.
ISD 281.0000, Refugee Eligibility Conditions, 6/29/1982.
ISD FA 610, Refugee Resettlement Program, 2/11/1988.
ISD FA 610, Refugee Resettlement Program, 7/2/1990.

History of Repealed Material:
8 NMAC 3.RRP, Refugee Resettlement Program - repealed, 7/1/1997.
8.119.410 NMAC - Recipient Policies -General Recipient Requirements (filed 3/2/2001) Repealed, effective 7/1/2024.

Other: 8.119.410 NMAC - Recipient Policies -General Recipient Requirements (filed 3/2/2001) Replaced by 8.119.410 NMAC - Recipient Policies -General Recipient Requirements, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 119 REFUGEE RESETTLEMENT PROGRAM
PART 500 ELIGIBILITY POLICY-GENERAL INFORMATION

8.119.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.119.500.1 NMAC - Rp 8.119.500.1 NMAC, 7/1/2024]

8.119.500.2 SCOPE: The rule applies to the general public.

[8.119.500.2 NMAC - Rp 8.119.500.2 NMAC, 7/1/2024]

8.119.500.3 STATUTORY AUTHORITY:

A. The Refugee Resettlement Program (RRP) is authorized under Title IV of the Immigration and Nationality Act of 1980. The act designates the federal department of health and human services (DHHS) as the federal administering agency. RRP regulations are issued by DHHS in the Code of Federal Regulations, Title 45, Part 400, which is supplemented by administrative and program instructions issued by the federal department from time to time.

B. In accordance with authority granted to the health care authority (HCA) by Subsection J of Section 27-1-3 NMSA 1978, and pursuant to executive order 80-62, dated 10/01/1981, the governor of the state of New Mexico has designated the HCA as the single state agency responsible for administering the program in New Mexico.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.119.500.3 NMAC - Rp 8.119.500.3 NMAC, 7/1/2024]

8.119.500.4 DURATION: Permanent.
[8.119.500.4 NMAC - Rp 8.119.500.4 NMAC, 7/1/2024]

8.119.500.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.119.500.5 NMAC - Rp 8.119.500.5 NMAC, 7/1/2024]

8.119.500.6 OBJECTIVE: The objective of the RRP is to assist refugees to become self-sufficient by providing a program of financial and medical assistance while, supportive services are provided, to ensure the effective resettlement of refugees in the state of New Mexico through programs designed to assist with integration, promotion of economic self-sufficiency, and protecting refugees and communities from infectious diseases and other health related issues. HCA has agreed to administer this program subject to the receipt of federal funds. Under the RRP, sponsors(s) and VOLAGs work closely with the federal government to coordinate support services authorized under the program. The RRP includes the provision of refugee cash assistance (RCA), refugee medical assistance (RMA), refugee social services (RSS) and additional support services funded by the office of refugee resettlement (ORR).
[8.119.500.6 NMAC - Rp 8.119.500.6 NMAC, 7/1/2024]

8.119.500.7 DEFINITIONS: [**RESERVED**]
[8.119.500.7 NMAC - Rp 8.119.500.7 NMAC, 7/1/2024]

8.119.500.8 NEED DETERMINATION:

A. Income and resource eligibility, as well as amount of payment, are determined in accordance with 45 CFR Section 400.66 which requires that RCA adhere to the need determination standards and provisions of the TANF program except as otherwise noted below:

(1) Resources remaining in the refugee's country of origin may not be counted in determining income eligibility.

(2) The income of a refugee's sponsor may not be counted in determining income eligibility.

(3) Any cash grant received by the refugee applicant under the U.S. department of state or department of justice reception and placement programs may not be counted in determining income eligibility.

B. Standard of need: Benefit group requirements are determined in accordance with 45 CFR Section 400.66 which requires that RCA adhere to the need determination standards and provisions of the TANF program.

C. Prospective budgeting: Need and income are determined prospectively in accordance with 45 CFR Section 400.66 which requires that RCA adhere to the need determination standards and provisions of the TANF program.
[8.119.500.8 NMAC - Rp 8.119.500.8 NMAC, 7/1/2024]

History of 8.119.500 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD-IPP 81-8, Limiting Assistance to 36 Months After Arrival into U.S. to Refugees (ISD Categories 19 and 49), 4/10/1981.
ISD-IPP 82-7, Limiting Refugee Assistance to 18 Months After Refugee's Arrival into U.S., 3/15/1982.
ISD 281.0000, Refugee Eligibility Conditions, 6/29/1982.
ISD FA 610, Refugee Resettlement Program, 2/11/1988.
ISD FA 610, Refugee Resettlement Program, 7/2/1990.

History of Repealed Material:
8 NMAC 3.RRP, Refugee Resettlement Program - Repealed, 07/01/1997.
8.119.500 NMAC - Eligibility Policy-General Information (filed 3/2/2001) Repealed, effective 7/1/2024.

Other: 8.119.500 NMAC - Eligibility Policy-General Information (filed 3/2/2001) Replaced by 8.119.500 NMAC - Eligibility Policy-General Information, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 119 REFUGEE RESETTLEMENT PROGRAM
PART 510 ELIGIBILITY POLICY-RESOURCES/ PROPERTY

8.119.510.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.119.510.1 NMAC - Rp 8.119.510.1, NMAC, 7/1/2024]

8.119.510.2 SCOPE: The rule applies to the general public.
[8.119.510.2 NMAC - Rp 8.119.510.2, NMAC, 7/1/2024]

8.119.510.3 STATUTORY AUTHORITY:

A. The Refugee Resettlement Program (RRP) is authorized under Title IV of the Immigration and Nationality Act of 1980. The Act designates the federal department of health and human services (DHHS) as the federal administering agency. RRP regulations are issued by DHHS in the code of federal regulations, Title 45, Part 400, which is supplemented by administrative and program instructions issued by the federal department from time to time.

B. In accordance with authority granted to the health care authority by Subsection J of Section 27-1-3 NMSA 1978, and pursuant to Executive Order No. 80-62, dated 10/01/1981, the governor of the state of New Mexico has designated the health care authority (HCA) as the single state agency responsible for administering the program in New Mexico.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.119.510.3 NMAC - Rp 8.119.510.3, NMAC, 7/1/2024]

8.119.510.4 DURATION: Permanent.
[8.119.510.4 NMAC - Rp 8.119.510.4, NMAC, 7/1/2024]

8.119.510.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.119.510.5 NMAC - Rp 8.119.510.5, NMAC, 7/1/2024]

8.119.510.6 OBJECTIVE: The objective of the RRP is to assist refugees to become self-sufficient by providing a program of financial and medical assistance while, supportive services are provided, to ensure the effective resettlement of refugees in the state of New Mexico through programs designed to assist with integration, promotion of economic self-sufficiency, and protecting refugees and communities from infectious diseases and other health related issues. HCA has agreed to administer this program subject to the receipt of federal funds. Under the RRP, sponsors(s) and VOLAGs work closely with the federal government to coordinate support services authorized under the program. The RRP includes the provision of refugee cash assistance (RCA), refugee medical assistance (RMA), refugee social services (RSS) and additional support services funded by the office of refugee resettlement (ORR).
[8.119.510.6 NMAC - Rp 8.119.510.6, NMAC, 7/1/2024]

8.119.510.7 DEFINITIONS: [**RESERVED**]
[8.119.510.7 NMAC - Rp 8.119.510.7, NMAC, 7/1/2024]

8.119.510.8 GENERAL: RCA need, with respect to resources, is determined in accordance with 45 CFR Section 400.66.
[8.119.510.8 NMAC - Rp 8.119.510.8, NMAC, 7/1/2024]

8.119.510.9 RESOURCE AVAILABILITY: Resource availability is determined in accordance with 45 CFR Section 400.66.
[8.119.510.9 NMAC - Rp 8.119.510.9, NMAC, 7/1/2024]

History of 8.119.510 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD-IPP 81-8, Limiting Assistance to 36 Months After Arrival into U.S. to Refugees (ISD Catagories 19 and 49), 4/10/81.
ISD-IPP 82-7, Limiting Refugee Assistance to 18 Months After Refugee's Arrival into U.S., 3/15/1982.
ISD 281.0000, Refugee Eligibility Conditions, 6/29/1982.
ISD FA 610, Refugee Resettlement Program, 2/11/1988.
ISD FA 610, Refugee Resettlement Program, 7/2/1990.

History of Repealed Material:
8 NMAC 3.RRP, Refugee Resettlement Program - Repealed, 07/01/1997.
8.119.510 NMAC - Eligibility Policy-Resources/Property (filed 3/2/2001) Repealed, effective, 7/1/2024.

Other: 8.119.510 NMAC - Eligibility Policy-Resources/Property (filed 3/2/2001) Replaced by 8.119.510 NMAC - Eligibility Policy-Resources/Property, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 150 LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
PART 100 GENERAL PROVISIONS FOR THE LOW INCOME HOME ENERGY ASSISTANCE PROGRAM

8.150.100.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.150.100.1 NMAC - 8.150.100.1 NMAC, 7/1/2024]

8.150.100.2 SCOPE: The rule applies to the general public.
[8.150.100.2 NMAC - 8.150.100.2 NMAC, 7/1/2024]

8.150.100.3 STATUTORY AUTHORITY: 27 NMSA 1978 (1992 Repl.) provides for the health care authority to "...adopt, amend and repeal bylaws, rules and regulations...". It also provides for administration of public assistance

programs. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.150.100.3 NMAC - 8.150.100.3 NMAC, 7/1/2024]

8.150.100.4 DURATION: Permanent.
[8.150.100.4 NMAC - 8.150.100.4 NMAC, 7/1/2024]

8.150.100.5 EFFECTIVE DATE: July 1, 2024, unless a different date is at the end of a section.
[8.150.100.5 NMAC - 8.150.100.5 NMAC, 7/1/2024]

8.150.100.6 OBJECTIVE: The objective of these regulations is to provide policy and procedures for the administration of the low-income home energy assistance program.
[8.150.100.6 NMAC - 8.150.100.6 NMAC, 7/1/2024]

8.150.100.7 DEFINITIONS: Unless otherwise apparent from the context, the following definition shall apply throughout these regulations. A life-threatening situation is a related emergency that poses a threat to the health or safety of one or more members of the household.
[8.150.100.7 NMAC - 8.150.100.7 NMAC, 7/1/2024]

8.150.100.8 STATUTORY AUTHORITY: The legal basis for the low income home energy assistance program (LIHEAP) is the Augustus F. Hawkins Human Services Reauthorization Act of 1990 (Public Law 101-501) as amended by Title III of the Human Services Amendments of 1994 (Public Law 103-252). Title XXVI of the Act is referred to as the Low Income Home Energy Assistance Act. The following sections cite the main statutory authorities for the state of New Mexico's administration of the LIHEAP grant award.
[8.150.100.8 NMAC - 8.150.100.8 NMAC, 7/1/2024]

8.150.100.9 SPECIFIC AUTHORITIES:

A. Assist eligible households: Section 2602(a) of the Low Income Home Energy Assistance Act states the purpose of LIHEAP is to assist eligible households in meeting the costs of home energy. HCA defines home energy as an energy expense that is incurred primarily for private residential heating or cooling.

B. Outreach: Section 2605(b)(3) of the administration for children and families (ACF) health and human services (HHS) office of the community services (OCS) LIHEAP statute requires the LIHEAP grantee to conduct outreach activities to ensure eligible households, and especially elderly and disabled households, are made aware of the LIHEAP program as well as similar energy-related assistance, utilizing nonprofit agencies as well as the grantee's own field offices in its outreach efforts.

C. Categorical eligibility: No household is categorically eligible to receive LIHEAP. Eligibility is determined during the application process.

D. Financial eligibility: Households must have income at or below one hundred fifty percent of the federal poverty guideline.

E. One hundred ten percent of state poverty level: Section 2605(b)(2)(B) of the ACF HHS OCS LIHEAP statute further states that no household may be excluded because of income if it has an income which is less than one hundred ten percent of the state poverty level.

F. Timely issuance of benefits: Section 2605(b)(5) of the ACF HHS OCS LIHEAP statute requires the LIHEAP grantee to provide energy assistance benefits in a timely manner as referenced in 8.100.130.11 NMAC.

G. Crisis funding: Section 2604 (C)(1) of the ACF HHS OCS LIHEAP statute requires the LIHEAP grantee to reserve a reasonable amount of funds for a crisis intervention program and to provide assistance to eligible households within 48 hours, excluding weekends and holidays, of the household's application for benefits. Subsection (2) further requires the LIHEAP grantee to provide assistance within 18 hours, excluding weekends and holidays, to eligible households that apply for benefits in a life-threatening situation.

H. Energy need and vulnerable populations: Section 2605 (b)(5) of the ACF HHS OCS LIHEAP statute requires the LIHEAP grantee to take into account the energy needs of low income households, giving priority to those having members of vulnerable populations such as young children, older individuals and individuals with disabilities.

I. Owners and renters: Section 2605(b)(8) of the ACF HHS OCS LIHEAP statute requires owners and renters to be treated equitably under the program.

J. Tribal LIHEAP: Section 2604(d)(1) of the ACF HHS OCS LIHEAP statute requires that a portion of the grant award be set aside for any Indian tribe in the state requesting an allocation of LIHEAP funds for the purpose of administering its own energy assistance program.

K. Administering agency: Section 2605(b)(6) of the ACF HHS OCS LIHEAP statute allows the grantee to designate local administrative agencies to carry out the program and to give special consideration to nonprofit agencies receiving federal funds for other energy-related assistance programs.
[8.150.100.9 NMAC - 8.150.100.9 NMAC, 7/1/2024]

8.150.100.10 MISSION STATEMENT:

A. Household related policies:

(1) HCA households: Households that receive benefits from programs administered by HCA will be notified of the LIHEAP application period. Those households that wish to apply for LIHEAP benefits may submit an application. It is HCA's policy to

issue regular benefits under this program to eligible households that apply for benefits during the specified period of application for regular benefits and that meet the income eligibility requirement and have a responsibility to pay for energy costs as specified in this policy.

(2) Non-HCA households: It is HCA's policy to issue regular benefits under this program to eligible households that receive no other assistance from HCA but that apply for LIHEAP benefits during the specified period of application for regular benefits and that meet the income eligibility requirement and have a responsibility to pay for energy costs as specified in this policy.

(3) Wood-primary heat source: With the exception of households that use wood as their primary heat source and gather their own wood supply, households that do not incur a direct or indirect home energy cost are not eligible.

(4) Renter with energy costs: Renters who meet the eligibility criteria and incur a home energy cost are eligible for benefits under this program.

(5) Homeless applicants who meet the eligibility criteria are eligible for benefits under this program. Applicants who do not incur an energy cost will not be allowed an energy burden as defined in Paragraph (1) of Subsection A of 8.150.620.9 NMAC.

B. Crisis intervention related policies:

(1) Crisis verification: Eligible households that have received a written disconnect notice from their utility vendor or a statement of non-delivery or sale of fuel from their fuel vendor due to lack of payment or inability to pay may be eligible to receive a LIHEAP benefit. When a crisis situation is identified, the HCA is required to provide intervention to resolve the energy crisis. The processing of an application for households in a crisis situation includes, a completed application, all necessary verification required to determine eligibility and contacting the vendor to intercede on the household's behalf to resolve the crisis situation. Eligible households with insufficient funds to open an account with a utility vendor or meet the security deposit requirements of a utility vendor may also be eligible to receive a LIHEAP benefit. These households must also be assisted with crisis intervention. Crisis intervention is not available to households that have received a LIHEAP benefit in the current federal fiscal year.

(2) Crisis situations for eligible households include, but are not limited to, the following scenarios:

(a) a written disconnect notice from utility vendor; or a statement of non-delivery; or sale of fuel from their fuel vendor due to lack of payment, or inability to pay;

(b) have twenty percent or less bulk fuel; or

(c) have less than a three day supply of firewood.

(3) A life threatening crisis situation for eligible crisis households include but are not limited to the following:

(a) households that contain a child age one or younger, or

(b) households that contain elderly age 60 or older, or

(c) households that contain a disabled member,

(d) and contain a household member that their health or wellbeing would likely be endangered if energy assistance is not provided.

(4) Crisis timeliness: Households who apply for LIHEAP benefits and provide documentation that a crisis situation exists will have their application processed in a timely manner.

(a) Assistance to resolve a crisis situation will be provided by the HCA within 48 hours, excluding weekends and holidays, of the receipt of the completed application for LIHEAP.

(b) Assistance to resolve a life-threatening crisis situation will be provided by the HCA within 18 hours, excluding weekends and holidays, of the receipt of the completed application for LIHEAP.

(5) Utility/vendor mediation: The LIHEAP benefit is intended to be a supplement to assist households with their energy bill. The ultimate responsibility for utility payments is the household's. The household will be notified that the LIHEAP benefit alone will not resolve their crisis situation. The household will be informed of other community resources.

[8.150.100.10 NMAC - 8.150.100.10 NMAC, 7/1/2024]

8.150.100.11 RESPONSIBILITIES AND DELEGATION: The income support division (ISD) of the HCA is responsible for administering the low income home energy assistance program (LIHEAP).

A. State LIHEAP plan: Every year, ISD submits a state plan to the U.S. department of health and human services (DHHS) for New Mexico's administration of LIHEAP. The proposed state plan and the proposed LIHEAP policy manual are made available for public comment and a public hearing is held.

B. LIHEAP administration: ISD is responsible for such matters as:

(1) formulating and interpreting LIHEAP policy;

(2) coordinating with other divisions within HCA for data processing of LIHEAP eligibility and payment;

(3) allocating and distributing LIHEAP monies;

(4) data entry of applicants/recipients information not available on the HCA's computer eligibility system; and

(5) oversight responsibility for LIHEAP policy and procedures training and for the review of all LIHEAP training materials.

[8.150.100.11 NMAC - 8.150.100.11

NMAC, 7/1/2024]

8.150.100.12 ISD FIELD OFFICE RESPONSIBILITIES: Each of the field offices of the income support division in the state is responsible for:

A. providing outreach and referrals regarding the LIHEAP program for low income applicants/recipients, particularly disabled and elderly applicants/recipients, crisis applicants/recipients, and households with high home energy burdens;

B. informing low-income households, particularly disabled and elderly applicants/recipients, about the eligibility determination process and application procedures for the LIHEAP program;

C. providing documentation to households requesting verification of cash benefits received from the HCA or other documentation available to the HCA or in the electronic case file;

D. complying with other LIHEAP program directives as may be issued by ISD;

E. assisting all applicant households to complete the LIHEAP application and resolving questionable information;

F. adhere to the deadlines as stated in Paragraph (2) of Subsection B of 8.150.100.10 NMAC when processing a crisis or life threatening crisis LIHEAP application, making the necessary vendor contact, and documenting the processing times accurately in the case notes;

G. entering the completed LIHEAP application into the designated LIHEAP computer system;

H. responding to inquiries about the status of a LIHEAP application; and

I. processing any payment errors when identified regardless of the amount; the ISD office must issue a supplement in cases of benefit under-issuances or complete the necessary actions to establish the claim for the over-issuance and refer to the restitution services bureau for recoupment.

[8.150.100.12 NMAC - 8.150.100.12 NMAC, 7/1/2024]

HISTORY OF 8.150.100 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD 600.0000, Energy Assistance Programs, 11/12/1982.
ISD 600.0000, Low Income Energy Assistance Program, 1/9/1984.
ISD 710.0000, Energy Assistance Programs, 11/15/1985.
ISD 620.0000, Crisis Intervention Assistance, 11/12/1982.
ISD 620.0000, Energy Crisis Intervention Assistance, 12/27/1983.
ISD 714.0000, Energy Crisis Intervention, 11-20-85.
ISD 630.0000, Program Administration, 11/12/1982.
ISD 630.0000, Program Administration, 12/27/1983.
ISD 715.0000, Administration of Energy Assistance Programs, 11/20/1985.
ISD FA 710, Energy Assistance Programs, 12/5/1989.
ISD CAS 700, Energy Assistance Program, 11/13/1991.
ISD CAS 700, Energy Assistance Program, 11/10/1992.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 5/6/1994.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 7/28/1994.

History of Repealed Material: 8.150.100 NMAC - General Provisions For The Low Income Home Energy Assistance Program (filed 9/17/2000), Repealed effective 7/1/2024.

Other: 8.150.100 NMAC - General Provisions For The Low Income Home Energy Assistance Program (filed 9/17/2000), Replaced by 8.150.100 NMAC - General Provisions For The Low Income Home Energy Assistance Program effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 150 LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
PART 110 APPLICATIONS

8.150.110.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.150.110.1 NMAC - Rp 8.150.110.1 NMAC, 7/1/2024]

8.150.110.2 SCOPE: The rule applies to the general public.
[8.150.110.2 NMAC - Rp 8.150.110.2 NMAC, 7/1/2024]

8.150.110.3 STATUTORY AUTHORITY: 27 NMSA 1978 (1992 Repl.) provides for the health care authority (HCA) to "...adopt, amend and repeal bylaws, rules and regulations...". It also provides for administration of public assistance programs. Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.150.110.3 NMAC - Rp 8.150.110.3 NMAC, 7/1/2024]

8.150.110.4 DURATION: Permanent.
[8.150.110.4 NMAC - Rp 8.150.110.4 NMAC, 7/1/2024]

8.150.110.5 EFFECTIVE DATE: July 1, 2024, unless a different date is at the end of a section or paragraph.
[8.150.110.5 NMAC - Rp 8.150.110.5 NMAC, 7/1/2024]

8.150.110.6 OBJECTIVE: The objective of these regulations is to provide policy and procedures for the administration of the low-income home energy assistance program.
[8.150.110.6 NMAC - Rp 8.150.110.6 NMAC, 7/1/2024]

8.150.110.7 DEFINITIONS:

[RESERVED]

8.150.110.8 RIGHT TO APPLY:

A. Recipients/ applicants: Anyone has the right to apply for any benefits provided by ISD whether or not it appears they will be eligible.

B. Outreach:

(1) HCA responsibilities: HCA conducts outreach regarding the LIHEAP program to eligible households, and particularly elderly and disabled households, through the ISD field offices and all of the offices and suboffices of the state's community action agencies. Additional outreach efforts to elderly and disabled households are made through workshops and conferences held by the state's agency on aging.

(2) Community action agency responsibility: HCA coordinates with the community action agencies to provide information and outreach services regarding LIHEAP and other energy-related assistance programs.

C. Barrier free policy: It is HCA's policy to make the application process for these households as barrier-free as possible. This includes:

(1) paperwork reduction and not requiring reverification by the household of information already available to HCA, such as SSI status;

(2) ease of access to physical locations where application may be made;

(3) provide access to the HCA's online application; and

(4) provide additional assistance for any recipient/ applicant who requires it.

D. Annual benefit: Each eligible household will be issued one benefit each federal fiscal year. The benefit may be issued in one or multiple payments depending on the funding availability and the approval of the HCA secretary. Receipt of a LIHEAP benefit from any other LIHEAP administering entity (tribe, state or territory) funded by HHS during any federal fiscal year would prohibit the receipt of LIHEAP in New Mexico during that FFY.

E. Supplemental benefit: A supplemental benefit may be established under certain conditions at the direction of the HCA secretary. A supplemental benefit may occur when:

(1) funding levels are predicted to exceed allowable carryover of federal funds to the next federal fiscal year;

(2) emergency weather circumstances.

[8.150.110.8 NMAC - Rp 8.150.110.8 NMAC, 7/1/2024]

8.150.110.9 SUBMISSION OF FORMS:

A. Applicants: Any household may apply for benefits during the specified application period:

(1) in person at any local county income support division office;

(2) through the online application; or

(3) submitting an application via mail or fax to any local county income support division office.

B. Application process: In order for a determination of eligibility for regular benefits to be made for these applicant households, the household's signed application must be received by the deadline date of the application period of October 1st through September 30th for each federal fiscal year. Required verification must be received by the 30th day after the received date stamped on the LIHEAP application.

C. Application period: The period of application for benefits will be year round beginning after the application for the LIHEAP grant has been submitted to the U.S. department of health and human services, and ending September 30. The application period is October 1st through September 30th for each federal fiscal year.

[8.150.110.9 NMAC - Rp 8.150.110.9 NMAC, 7/1/2024]

8.150.110.10 DISPOSITION OF APPLICATION/NOTICE:

A. Income support division county office responsibilities: Households who complete the application process for LIHEAP benefits will be provided with a notice indicating whether they have been approved or denied. Upon acknowledgement of payment by the vendor, households will be provided with a notice indicating that they have been approved. Upon determination of ineligibility by HCA, households will be provided with a notice indicating that they have been denied. If the household fails to provide the verification required to determine eligibility, ISD may deny the application after 30 days from the date of the application.

B. LIHEAP central office responsibilities: LIHEAP central office staff will complete random reviews of LIHEAP approvals and denials. The review will verify whether LIHEAP policy was correctly applied. If an eligibility error is found or the application is incomplete, a determination will be made to identify any payment errors.

C. Notices: All households will be mailed a notice indicating whether they have been approved or denied for LIHEAP benefits. The notice indicating that an applicant has been approved will list the point calculation, point total, the benefit amount and the method of issuance. The notice indicating that an applicant has been denied will indicate the denial reason.

[8.150.110.10 NMAC - Rp 8.150.110.10 NMAC, 7/1/2024]

HISTORY OF 8.150.110 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD 600.0000, Energy Assistance Programs, 11/12/1982.

ISD 600.0000, Low Income Energy Assistance Program, 1/9/1984.

ISD 710.0000, Energy Assistance Programs, 11/15/1982.

ISD 620.0000, Crisis Intervention

Assistance, 11/12/1982.
ISD 620.0000, Energy Crisis Intervention Assistance, 12/27/1983.
ISD 714.0000, Energy Crisis Intervention, 11/20/1985.
ISD 630.0000, Program Administration, 11/12/1982.
ISD 630.0000, Program Administration, 12/27/1983.
ISD 715.0000, Administration of Energy Assistance Programs, 11/20/1985.
ISD FA 710, Energy Assistance Programs, 12/5/1989.
ISD CAS 700, Energy Assistance Program, 11/13/1991.
ISD CAS 700, Energy Assistance Program, 11/10/1992.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 5/6/1994.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 7/28/1994.

History of Repealed Material: 8.150.110 NMAC - Applications (filed 9/17/2001), Repealed effective 7/1/2024.

Other: 8.150.110 NMAC - Applications (filed 9/17/2001), Replaced by 8.150.110 NMAC - Applications, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 150 LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
PART 410 GENERAL RECIPIENT REQUIREMENTS

8.150.410.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.150.410.1 NMAC - Rp 8.150.410.1 NMAC, 7/1/2024]

8.150.410.2 SCOPE: The rule applies to the general public.
[8.150.410.2 NMAC - Rp 8.150.410.2 NMAC, 7/1/2024]

8.150.410.3 STATUTORY AUTHORITY: 27 NMSA 1978 (1992 Repl.) provides for the health care authority (HCA) to "...adopt, amend and repeal bylaws, rules and regulations...". It also provides for administration of public assistance programs. Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.150.410.3 NMAC - Rp 8.150.410.3 NMAC, 7/1/2024]

8.150.410.4 DURATION: Permanent.
[8.150.410.4 NMAC - Rp 8.150.410.4 NMAC, 7/1/2024]

8.150.410.5 EFFECTIVE DATE: July 1, 2024, unless a different date is at the end of a section.
[8.150.410.5 NMAC - Rp 8.150.410.5 NMAC, 7/1/2024]

8.150.410.6 OBJECTIVE: The objective of these regulations is to provide policy and procedures for the administration of the low income home energy assistance program (LIHEAP).
[8.150.410.6 NMAC - Rp 8.150.410.6 NMAC, 7/1/2024]

8.150.410.7 DEFINITIONS: [**RESERVED**]

8.150.410.8 HOUSEHOLD UNIT: For purposes of LIHEAP, a household is an individual, or group of individuals living together, who incurs a heating or cooling cost. The heating or cooling cost must be to meet residential, not business or industrial, heating or cooling needs.
[8.150.410.8 NMAC - Rp 8.150.410.8 NMAC, 7/1/2024]

8.150.410.9 ENERGY RESPONSIBILITY:

A. Energy cost: To be eligible for LIHEAP benefits, the household must incur an energy cost. The energy cost may be for a primary heat source, i.e., the energy source or fuel with which the household is predominantly heated, or for a secondary heat source. A secondary heat source is an energy source that is essential to the process of providing heat to the home. The energy cost may be for a cooling cost. The cooling cost may be for a primary source, i.e., evaporative cooling or refrigerated air, or secondary cooling. Secondary cooling is the use of energy to operate portable fans, ceiling fans, whole house fans, gable vent fans, or power attic vent fans.

B. Secondary heat source: Electricity to ignite a gas or steam furnace is the most common example of an allowable secondary heat source for LIHEAP purposes. Electricity used only for lighting purposes or to operate fans to distribute heat from a wood-burning stove is not considered an allowable secondary heat source for LIHEAP purposes.

C. Wood-gathering households: Households who use wood as a fuel to heat their home and gather the wood themselves are considered to have a heating responsibility. Regardless of whether a direct or indirect cost was incurred to obtain the wood the household meets this requirement.

D. Direct or indirect utility responsibility: The heating/cooling cost may be direct in the form of a utility payment or fuel purchase, or indirect in the form of a non-subsidized rent payment which either designates or does not designate the included utility cost, or costs associated with obtaining wood for heating households.

E. Crisis intervention: To be eligible for LIHEAP regular or life-threatening crisis intervention, the household must meet the eligibility criteria for regular benefits as specified in 8.150.500.8 NMAC, must not have received a LIHEAP benefit in the current federal fiscal year and, in addition, be able to provide verification that proves the applicant household is facing a current or impending energy crisis, established with any one of the following:

(1) current notice of disconnect for the household from a utility vendor; or

(2) applicant written or verbal statement of insufficient funds for the household to open an account with a utility vendor or meet the security deposit requirements of a utility vendor; or

(3) statement from the household's fuel vendor that fuel will not be provided without payment.

(4) Life-threatening crisis intervention: The applicant must meet the above criteria for a regular crisis intervention and in addition provide a written or verbal statement advising that the household faces an emergency which poses a threat to the health or safety of one or more members of the household.

F. Community referrals: In circumstances where the household is not eligible for crisis intervention, or if a balance remains after the crisis/life threatening intervention has been provided, the household shall be informed of other resources in the community, which may be able to assist the household in meeting its energy expenses.
[8.150.410.9 NMAC - Rp 8.150.410.9 NMAC, 7/1/2024]

8.150.410.10 [**RESERVED**]
[8.150.410.10 NMAC - Rp 8.150.410.10 NMAC, 7/1/2024]

8.150.410.11 HOUSING TYPE:

A. Non-subsidized rent: Non-subsidized rent is defined as an obligation to pay for shelter which is entirely the responsibility of the household incurring the expense.

(1) Separate direct costs: Households paying non-subsidized rent who incur a separate heating/cooling cost are eligible for LIHEAP.

(2) Utilities included in rent: Households paying non-subsidized rent whose utility costs are included in their rent, even if no such cost is designated, are eligible for LIHEAP.

B. Subsidized rent: Subsidized rent assistance is defined as a payment for shelter, or shelter and utilities, the cost of which has been reduced due to a subsidy from a housing or other assistance program. University housing does not meet this definition and is therefore not considered subsidized housing.

(1) Separate direct costs: Households receiving subsidized rent assistance who incur a separate direct cost for heating/cooling are eligible for LIHEAP benefits;

(2) Subsidized rent/utilities with additional separate utility cost: Households receiving subsidized rent assistance who receive a subsidy for utilities but who incur an additional out-of-pocket expense for utilities are eligible for LIHEAP;

(3) Subsidized rent with utilities included: Households receiving subsidized rent assistance whose heating/cooling cost is included in their subsidized rent and do not incur an additional out-of-pocket heating or cooling expense are not eligible for LIHEAP;

(4) Subsidized rent with rental cost: Households receiving subsidized rent assistance who pay rent but do not pay utilities are not eligible for LIHEAP; and,

(5) Subsidized rent with no cost: Households receiving subsidized rent assistance who pay no rent and no utilities are not eligible for LIHEAP;

C. Mortgaged or free and clear home: Households who pay a mortgage or own their own home and incur a separate heating/cooling cost are eligible for LIHEAP.
[8.150.410.11 NMAC - Rp 8.150.410.11 NMAC, 7/1/2024]

8.150.410.12 INDIAN TRIBAL ELIGIBILITY: In New Mexico, an Indian tribe may choose to administer its own LIHEAP program for tribal members and request from DHHS an allocation of the state's share of the LIHEAP grant award for this purpose. An Indian tribe is defined as a legal entity of a group of Native Americans living on tribal lands with a distinct and separate government. Residents of tribal land may be eligible for tribal administered LIHEAP or HCA-administered LIHEAP under the following circumstances.

A. Tribes that administer LIHEAP: Indian tribal members living on their tribe's tribal lands, whose tribe administers their own LIHEAP program, are not eligible for HCA-administered LIHEAP benefits.

B. Tribes not administering LIHEAP: Indian tribal members living on the tribal lands of tribes not administering their own LIHEAP program may be considered for HCA-administered LIHEAP benefits providing they meet income eligibility and heating/cooling responsibility requirements as specified in this policy.

C. Indians on other tribes' land: Households that are members of Indian tribes administering their own LIHEAP program but not living on their tribe's tribal lands, may be considered for HCA-administered LIHEAP benefits providing they meet income eligibility and heating responsibility requirements, as specified in this policy, and they did not receive LIHEAP benefits from their tribal government for the current LIHEAP season.

D. Non-Indians and non-tribal members on tribal land: Non-Indians living on tribal lands and Indians living on tribal lands who are excluded from eligibility for LIHEAP by the Indian tribe administering their own LIHEAP program may be considered for HCA-administered LIHEAP benefits providing they meet income eligibility and heating/cooling responsibility requirements as specified in this policy.

E. At the direction of the HCA secretary, HCA may serve tribal members normally excluded due to Subsection A of 8.150.410.12 NMAC if they have not been or do not expect to be served by the tribal LIHEAP program.
[8.150.410.12 NMAC - Rp 8.150.410.12 NMAC, 7/1/2024]

8.150.410.13 CITIZENSHIP: To be eligible, a LIHEAP household

must contain at least one member who is a (1) U.S. citizen, or (2) a qualified non-citizen considered eligible to participate in the TANF program. See 8 USC Sec. 1641, Title 8, Chapter 14, Subchapter IV, and any subsequent changes.
[8.150.410.13 NMAC - Rp 8.150.410.13 NMAC, 7/1/2024]

8.150.410.14 RESIDENCY: To be eligible, a LIHEAP household must have a residence in New Mexico and be occupying that residence at the time of application. The LIHEAP benefit must be applied toward the utility or fuel costs incurred for that residence.
[8.150.410.14 NMAC - Rp 8.150.410.14 NMAC, 7/1/2024]

8.150.410.15 ENUMERATION: To be eligible for inclusion in the LIHEAP benefit group, a social security number (SSN) or proof of application for a number must be provided for each citizen and qualified non-citizen for which assistance is being requested. Any member(s) of a LIHEAP applicant household who do not meet the requirements of this section will not be eligible for a LIHEAP benefit.
[8.150.410.15 NMAC - Rp 8.150.410.15 NMAC, 7/1/2024]

8.150.410.16 RESIDENCE IN FACILITY OR INSTITUTION: Persons residing in New Mexico but living in group homes, halfway houses, institutions, homeless shelters, or in places not normally intended for human occupation are not eligible unless they can document heating/cooling expenses.
[8.150.410.16 NMAC - Rp 8.150.410.16 NMAC, 7/1/2024]

8.150.410.17 RECIPIENT RIGHTS:

A. Treatment and non-discrimination: Members of a household shall have the right, at all times, to be treated with dignity at all times. Household members may not be discriminated against on the basis of age, sex, race, color, handicap, national origin, or religious or political belief.

B. Confidentiality: Household members have the right to confidentiality as defined in 8.100.100.13 NMAC.

C. Fair hearings: The household has the right to disagree with the determinations made by HCA and to appeal such actions through HCA's fair hearing process.
[8.150.410.17 NMAC - Rp 8.150.430.8 NMAC, 7/1/2024]

8.150.410.18 RECIPIENT RESPONSIBILITIES:

A. Benefit purpose: The household is responsible for using the benefit received for the purpose intended.

B. Erroneously issued benefits: If it is determined the household is not entitled to the benefit received, whether agency or recipient caused, the household is responsible for paying back the benefits received. The household is responsible for repayment whether the benefit was received directly by the household or paid to a vendor per Subsection H of 8.150.100.12 NMAC, a claim must be established for any erroneous benefit issuance.
[8.150.410.18 NMAC - Rp 8.150.410.18 NMAC, 7/1/2024]

HISTORY OF 8.150.410 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD 600.0000, Energy Assistance Programs, 11/12/1982.
ISD 600.0000, Low Income Energy Assistance Program, 1/9/1984.
ISD 710.0000, Energy Assistance Programs, 11/15/1985.
ISD 620.0000, Crisis Intervention Assistance, 11/12/1982.
ISD 620.0000, Energy Crisis Intervention Assistance, 12/27/1983.
ISD 714.0000, Energy Crisis Intervention, 11/20/1985.
ISD 630.0000, Program Administration, 11/12/1982.
ISD 630.0000, Program Administration, 12/27/1983.
ISD 715.0000, Administration of Energy Assistance Programs, 11/20/1985.
ISD FA 710, Energy Assistance Programs, 12/5/1989.
ISD CAS 700, Energy Assistance Program, 11/13/1991.
ISD CAS 700, Energy Assistance Program, 11/10/1992.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 5/6/1994.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 7/28/1994.

History of Repealed Material:
8.150.410 NMAC - General Recipient Requirements (filed 9/17/2001), Repealed effective 7/1/2024.

Other: 8.150.410 NMAC - General Recipient Requirements (filed 9/17/2001), Replaced by 8.150.410 NMAC - General Recipient Requirements effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 150 LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
PART 500 ELIGIBILITY

8.150.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.150.500.1 NMAC - Rp 8.150.500.1 NMAC, 7/1/2024]

8.150.500.2 SCOPE: The rule applies to the general public.
[8.150.500.2 NMAC - Rp 8.150.500.2 NMAC, 7/1/2024]

8.150.500.3 STATUTORY AUTHORITY: Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. It also provides for administration of public assistance programs.
[8.150.500.3 NMAC - Rp 8.150.500.3

NMAC, 7/1/2024]

8.150.500.4 DURATION: Permanent.
[8.150.500.4 NMAC - Rp 8.150.500.4 NMAC, 7/1/2024]

8.150.500.5 EFFECTIVE DATE: July 1, 2024, unless a different date is at the end of a section.
[8.150.500.5 NMAC - Rp 8.150.500.5 NMAC, 7/1/2024]

8.150.500.6 OBJECTIVE: The objective of these regulations is to provide policy and procedures for the administration of the low-income home energy assistance program (LIHEAP).
[8.150.500.6 NMAC - Rp 8.150.500.6 NMAC, 7/1/2024]

8.150.500.7 DEFINITIONS: [**RESERVED**]

8.150.500.8 NEED DETERMINATION: To be eligible for LIHEAP benefits households must do the following:

A. An applicant/recipient or representative must complete an application for LIHEAP benefits and will be interviewed face to face or telephonically only if information is questionable, to determine crisis or life threatening situations, or if the client has not been interviewed by the HCA for any other ISD program 30 days prior to the application date stamped on the application.

B. The household must provide proof that they meet the qualifications of the LIHEAP program; current documents used in other public assistance programs may be used for LIHEAP application processes, unless questionable:

(1) proof of identity for the applicant using any of the following documentation:

(a) birth certificates(s); or

(b) baptism certificate; or

(c) hospital or birth record; or

(d) divorce papers; or

(e) alien registration card; or

(f) immigration & naturalization service (INS) records; or

(g) U. S. passport; or

(h) Indian census records; or

(i) family bible; or

(j) school or day care records; or

(k) government records; or

(l) social security records; or

(m) social service records; or

(n) insurance policy; or

(o) court records; or

(p) church records; or

(q) voter registration card; or

(r) letter from doctor, religious official or school official, or someone else who knows the applicant; or

(s) applicant sworn statement;

(2) proof of citizenship or legal resident status if questionable, such as birth certificate, permanent resident card, naturalization papers, etc.;

(3) social security numbers for all household members requesting assistance; a social security card is required if the HCA is not able to validate or if the number is questionable;

(4) proof of gross income for all household members, such as check stubs, award letters, statement from employer, etc.;

(5) proof of a utility responsibility with an expense incurred in the past twelve months for the household's current residence:

(a) bill for metered service for a one-month period, or

(b) two consecutive purchase receipts for propane, or a history of the account from the vendor, or

(c) receipt for wood purchase which includes a statement from the applicant of the duration of use for said wood, or

(d) rental agreement or landlord statement that utilities are included in rent, or

(e) from the utility or fuel vendor, a signed statement or billing history;

(6) account number at current address for the selected heating or cooling expense;

(7) proof of crisis when the situation exists, such as a current disconnect notice, statement of non-delivery of bulk fuel or statement detailing the cost of initiating service;

(8) proof of a life-threatening crisis when the situation exists, such as a current disconnect notice, statement of non-delivery of bulk fuel or statement detailing the cost of initiating service and a written or verbal statement from the applicant advising that the household faces an emergency which poses a threat to the health or safety of one or more members of the household;

(9) proof of disability for at least one household member as determined by another public assistance or federal or state entity;

(10) proof of emergency expenditures that apply to 8.150.520.18 NMAC; and

(11) proof of the household's main fuel expense for the household's current residence, if applicant/recipient is not requesting LIHEAP for assistance with the main heating or cooling fuel source.

C. eligibility criteria: the household must meet the identity, social security number, income, citizenship, utility responsibility, and residency requirements.
[8.150.500.8 NMAC - Rp 8.150.500.8 NMAC, 7/1/2024]

8.150.500.9 [RESERVED]
[8.150.500.9 NMAC - Rp 8.150.500.9 NMAC, 7/1/2024]

8.150.500.10 [RESERVED]
[8.150.500.10 NMAC - Rp 8.150.500.10 NMAC, 7/1/2024]

HISTORY OF 8.150.500 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD 600.0000, Energy Assistance Programs, 11/12/1982.
ISD 600.0000, Low Income Energy Assistance Program, 1/9/1984.
ISD 710.0000, Energy Assistance Programs, 11/15/1985.
ISD 620.0000, Crisis Intervention Assistance, 11/12/1982.
ISD 620.0000, Energy Crisis Intervention Assistance, 12/27/1983.
ISD 714.0000, Energy Crisis Intervention, 11/20/1985.
ISD 630.0000, Program Administration, 11/12/1982.
ISD 630.0000, Program Administration, 12/27/1983.
ISD 715.0000, Administration of Energy Assistance Programs, 11/20/1985.
ISD FA 710, Energy Assistance Programs, 12/5/1989.
ISD CAS 700, Energy Assistance Program, 11/13/1991.
ISD CAS 700, Energy Assistance Program, 11/10/1992.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 5/6/1994.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 7/28/1994.

History of Repealed Material:
8.150.500 NMAC - Eligibility (filed 9/17/2001), Repealed 7/1/2024.

Other: 8.150.500 NMAC - Eligibility (filed 9/17/2001), Replaced by 8.150.500 NMAC - Eligibility, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 150 LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
PART 510 RESOURCES/ PROPERTY

8.150.510.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.150.510.1 NMAC - Rp 8.150.510.1 NMAC, 7/1/2024]

8.150.510.2 SCOPE: The rule applies to the general public.
[8.150.510.2 NMAC - Rp 8.150.510.2 NMAC, 7/1/2024]

8.150.510.3 STATUTORY AUTHORITY: Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. It also provides for administration of public assistance programs.
[8.150.510.3 NMAC - Rp 8.150.510.3 NMAC, 7/1/2024]

8.150.510.4 DURATION: Permanent.
[8.150.510.4 NMAC - Rp 8.150.510.4 NMAC, 7/1/2024]

8.150.510.5 EFFECTIVE DATE: July 1, 2024, unless a different date is at the end of a section.
[8.150.510.5 NMAC - Rp 8.150.510.5 NMAC, 7/1/2024]

8.150.510.6 OBJECTIVE: The objective of these regulations is to provide policy and procedures for the administration of the low income home energy assistance program (LIHEAP).
[8.150.510.6 NMAC - Rp 8.150.510.6 NMAC, 7/1/2024]

8.150.510.7 DEFINITIONS: [RESERVED]

8.150.510.8 RESOURCE STANDARDS/ELIGIBILITY: No assets test is required to be eligible for LIHEAP benefits.
[8.150.510.8 NMAC - Rp 8.150.510.8 NMAC, 7/1/2024]

HISTORY OF 8.150.510 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD 600.0000, Energy Assistance Programs, 11/12/1982.
ISD 600.0000, Low Income Energy Assistance Program, 1/9/1984.
ISD 710.0000, Energy Assistance Programs, 11/15/1985.
ISD 620.0000, Crisis Intervention Assistance, 11/12/1982.
ISD 620.0000, Energy Crisis Intervention Assistance, 12/27/1983.
ISD 714.0000, Energy Crisis Intervention, 11/20/1985.
ISD 630.0000, Program Administration, 11/12/1982.
ISD 630.0000, Program Administration, 12/27/1983.
ISD 715.0000, Administration of Energy Assistance Programs, 11/20/1985.
ISD FA 710, Energy Assistance Programs, 12/5/1989.
ISD CAS 700, Energy Assistance Program, 11/13/1991.
ISD CAS 700, Energy Assistance Program, 11/10/1992.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 5/6/1994.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 7/28/1994.

History of Repealed Material:
8.150.510 NMAC - Resources/ Property (filed 9/17/2001), Repealed effective 7/1/2024.

Other: 8.150.510 NMAC - Resources/Property (filed 9/17/2001), Replaced by 8.150.510 NMAC - Resources/Property, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 150 LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
PART 520 INCOME

8.150.520.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.150.520.1 NMAC - Rp 8.150.520.1 NMAC, 7/1/2024]

8.150.520.2 SCOPE: The rule applies to the general public.
[8.150.520.2 NMAC - Rp 8.150.520.2 NMAC, 7/1/2024]

8.150.520.3 STATUTORY AUTHORITY: Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. It also provides for administration of public assistance programs.
[8.150.520.3 NMAC - Rp 8.150.520.3 NMAC, 7/1/2024]

8.150.520.4 DURATION: Permanent.
[8.150.520.4 NMAC - Rp 8.150.520.4 NMAC, 7/1/2024]

8.150.520.5 EFFECTIVE DATE: July 1, 2024, unless a different date is at the end of a section.
[8.150.520.5 NMAC - Rp 8.150.520.5 NMAC, 7/1/2024]

8.150.520.6 OBJECTIVE: The objective of these regulations is to provide policy and procedures for the administration of the low income home energy assistance program (LIHEAP).
[8.150.520.6 NMAC - Rp 8.150.520.6 NMAC, 7/1/2024]

8.150.520.7 DEFINITIONS: [RESERVED]

8.150.520.8 EARNED GROSS INCOME:

A. Definitions: Earned gross income is defined as income received in the form of wages paid on a predetermined regular basis, pay received irregularly for work performed irregularly, or income resulting from self-employment activities. Income from rental property, if 20 hours or more per week are spent working as a landlord, is also countable as earned income.

B. Exclusions: The following are not counted as gross income:

(1) in-kind benefits: (i.e. good or services realized, provided or exchanged for non-monetary compensation);

(2) vendor payments: (i.e. payments made on behalf of a household to a third party);

(3) lump sum payments: see food stamp regulations on lump sum payments in 8.139.520.9 NMAC;

(4) loans;

(5) charitable contributions from nonprofit agencies to meet household expenses;

(6) earned income tax credits;

(7) value of food stamps;

(8) TANF annual clothing allowance;

(9) monies received for the care of a third party beneficiary who is not a household member; and

(10) monies excluded by federal statute, a listing of which can be found in food stamp policy citation 8.139 NMAC.
[8.150.520.8 NMAC - Rp 8.150.520.8 NMAC, 7/1/2024]

8.150.520.9 SELF EMPLOYMENT GROSS INCOME:

A. Definition: Ongoing self-employment income intended to support the household through the year, that is averaged over a 12 month period, even if the household earns the money in a concentrated period. Self-employment income intended to support the household only for a portion of the year must be averaged over the months it is intended to provide support.

B. Verification sources: Monthly business records detailing profits and expenses or the household's federal income tax return are needed to annualize the household's self-employment income.

C. Gross income calculation: For self-employment income, the net income of the business activity is considered the gross income of the household member. The net income of the business is derived by subtracting the allowable costs of doing business from the business's gross income.

D. Business expenses:

(1) Allowable costs are, generally, those required to produce the business's gross income. These include, but are not limited, to: raw materials, stock, labor, insurance premiums, interest paid on income producing property, taxes paid on income-producing property, transportation for business purposes.

(2) Costs specifically not allowed are payments on the principal of the purchase price of income-producing property, assets, equipment, or machinery, net losses from previous periods, personal income taxes, money set aside for personal expenses, transportation to and from work, charitable contributions, entertainment, and depreciation.

E. Annualizing income: From gross self-employment income, subtract allowable expenses to derive the net self-employment income. Divide the net self-employment income by 12 to produce a monthly (average) figure. This figure is the countable monthly gross income. To determine the household's total gross, this figure must be added to any other income the household receives.
[8.150.520.9 NMAC - Rp 8.150.520.9 NMAC, 7/1/2024]

8.150.520.10 GROSS INCOME OF INELIGIBLE NON-CITIZENS: The gross income received by any ineligible non-citizen household member must be prorated and counted to establish the benefit

amount.

A. Definition: If any member of the household providing income to the household is an ineligible non-citizen for TANF purposes, that member's income is not counted in its entirety but is prorated. Prorating results in excluding a portion of the ineligible non-citizen household member's income from consideration because the ineligible non-citizen is not a recipient of public assistance benefits.

B. Proration calculation: Calculate the gross income of the ineligible non-citizen and divide the total by the number of members, eligible and ineligible, in the household. The resulting figure is the pro-rata portion of the income for each member, eligible and ineligible. To determine the portion of the income to be counted, multiply the pro rata portion by the remaining number of eligible household members.

[8.150.520.10 NMAC - Rp 8.150.520.10 NMAC, 7/1/2024]

8.150.520.11 GROSS INCOME OF MIGRANT HOUSEHOLDS:

A. Definition: A migrant household is a group that travels away from home on a regular basis with a group of laborers to seek employment in an agriculturally related activity.

B. Verification sources: The household's federal income tax return is needed to annualize the household's income.

C. Calculation: The household's annual income reported on their federal income tax return should be divided by 12 to determine the household's average monthly income.

[8.150.520.11 NMAC - Rp 8.150.520.11 NMAC, 7/1/2024]

8.150.520.12 GROSS INCOME DETERMINATION: Gross income of the household member is defined as all income received prior to deductions, including taxes, garnishments, whether voluntary or involuntary and net business income.

A. Income sources: Gross income includes income from both earned and unearned sources.

B. Countable income: The gross unearned income of all household members is counted in its entirety, and the gross earned income of all household members over the age of 18 is counted in its entirety, unless:

(1) the income is specifically exempted; or

(2) the income is self-employment, in which case the income is annualized (see LIHEAP 8.150.520.9 NMAC); or

(3) the income is that of an ineligible non-citizen, in which case the income is prorated (see LIHEAP policy 8.150.520.10 NMAC);

(4) the income is a full month's income and is anticipated to be received on a weekly or biweekly basis; in these circumstances, the income shall be converted to a monthly amount as follows:

(a) income received on a weekly basis is averaged and multiplied by four;

(b) income received on a biweekly basis is averaged and multiplied by two;

(c) averaged income shall be rounded to the nearest whole dollar prior to application of the conversion factor; amounts resulting in $0.50 or more are rounded up; amounts resulting in $0.49 or lower are rounded down.

C. Gross income receipt period: HCA shall establish income by utilizing the gross income of the household for the 30 day period immediately preceding the date on which LIHEAP eligibility is determined by ISD.

D. Current income verified in other public assistance programs: Current income that has been verified by ISD in another active public assistance programs may be used to verify income for the LIHEAP application, unless deemed questionable.

[8.150.520.12 NMAC - Rp 8.150.520.12 NMAC, 7/1/2024]

8.150.520.13 UNEARNED INCOME:

A. Definition: Unearned income is income received in the form of entitlement, disability, retirement, unemployment benefits or payments, including but not limited to the following:

(1) child support;

(2) alimony;

(3) temporary assistance to needy families (TANF) benefits;

(4) general assistance (GA) payments;

(5) royalties;

(6) dividends and interest; or

(7) tribal benefits.

B. Gross unearned income: The gross amount of the benefit or payment must be counted. In the case of OASDI benefits, the gross amount of the benefit includes the amount deducted for the medicare premium, if applicable.

C. Real estate contracts: Monthly payments resulting from the sale of property and contributions from family or friends are also countable unearned income.

D. Exclusions: The following are not counted as income:

(1) in-kind benefits (i.e. goods or services realized, provided or exchanged for non-monetary compensation);

(2) vendor payments (i.e. payments made on behalf of a household to a third party);

(3) lump sum payments: as defined in food stamp regulations at 8.139.520.9 NMAC;

(4) loans;

(5) charitable contributions from nonprofit agencies to meet household expenses;

(6) earned income tax credits;

(7) value of food stamps;

(8) TANF annual clothing allowance;

(9) monies received for the care of a third party beneficiary who is not a household

member; and

(10) monies excluded by federal statute, as listed at 8.139.527 NMAC.

[8.150.520.13 NMAC - Rp 8.150.520.13 NMAC, 7/1/2024]

8.150.520.14 TOTAL GROSS INCOME: The household's total gross income is determined by adding countable earned and unearned income. Income received from self-employment and by ineligible non-citizens is not counted in full. The income of migrant households may be annualized and averaged. The household's total gross income must be equal to or less than income standards published annually in the LIHEAP state plan.

[8.150.520.14 NMAC - Rp 8.150.520.14 NMAC, 7/1/2024]

8.150.520.15 INCOME STANDARD: Income guidelines for eligibility will be updated at the beginning of each federal fiscal year as required by federal statute. The guidelines will be effective for the entire federal fiscal year beginning October 1 and ending September 30. The income guidelines will be determined by the secretary of the HCA before the beginning of the new federal fiscal year and published annually in the LIHEAP state plan.

[8.150.520.15 NMAC - Rp 8.150.520.15 NMAC, 7/1/2024]

8.150.520.16 CRISIS INTERVENTION STANDARDS: Households who are over the income standards but meet the crisis intervention requirements may be eligible for a crisis LIHEAP benefit. If a household is over the income standards, HCA staff should explore the household's financial circumstances and take into account any financial crisis in the household that may have resulted in the household's inability to meet its utility or fuel expenses in the past 30 days. In these cases, the household's net income, rather than gross income, may be considered to determine income eligibility for LIHEAP benefits.

[8.150.520.16 NMAC - Rp 8.150.520.16 NMAC, 7/1/2024]

8.150.520.17 NET INCOME:

A. Definition: Net income, except for net business income, for the purposes of LIHEAP policy, is not gross income minus deductions. Rather, it is gross income minus household emergency expenses incurred and paid in 30 days prior to the application date or the initial payment, during that period, of a bill resulting from a recent household emergency.

B. Calculation: To determine the net income for a household, subtract any allowable household emergency expenses from the household's gross income.

C. No emergency expenses: If the household did not incur and pay household emergency expenses or an initial payment for a recent household emergency in the 30 days prior to the application date for LIHEAP benefits, gross income is to be used to make the determination of eligibility.

[8.150.520.17 NMAC - Rp 8.150.520.17 NMAC, 7/1/2024]

8.150.520.18 HOUSEHOLD EMERGENCY EXPENSES:

A. Definition: Household emergency expenses are defined as expenses incurred and paid in full or in part by the household in the 30 days prior to the application date.

B. Examples of emergency expenses include:

(1) hospital, ambulance, doctor and dental bills;

(2) laboratory and other testing bills;

(3) prescriptions and non-prescription items ordered by a licensed health care professional; and

(4) services provided or ordered by a licensed health care professional; or

(5) non-elective medical expenses;

(6) emergency medical expenses, such as:

(7) hospital bills; and

(8) ambulance bills;

(9) expenses resulting from the death of a household member or other major household crisis; or

(10) repair or replacement of the household's primary vehicle.

C. Licensure exemption: Native American practitioners (medicine men), though not licensed by the state, are specifically recognized by HCA as health care providers under this policy.

[8.150.520.18 NMAC - Rp 8.150.520.18 NMAC, 7/1/2024]

8.150.520.19 VERIFICATION: To be considered, the household must provide proof of the incurred expense(s) and proof of payment.

[8.150.520.19 NMAC - Rp 8.150.520.19 NMAC, 7/1/2024]

HISTORY OF 8.150.520 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD 600.0000, Energy Assistance Programs, 11/12/1982.

ISD 600.0000, Low Income Energy Assistance Program, 1/9/1984.

ISD 710.0000, Energy Assistance Programs, 11/15/1985.

ISD 620.0000, Crisis Intervention Assistance, 11/12/1982.

ISD 620.0000, Energy Crisis Intervention Assistance, 12/27/1983.

ISD 714.0000, Energy Crisis Intervention, 11/20/1985.

ISD 630.0000, Program Administration, 11/12/1982.

ISD 630.0000, Program Administration, 12/27/1983.

ISD 715.0000, Administration of Energy Assistance Programs, 11/20/1985.

ISD FA 710, Energy Assistance Programs, 12/5/1989.

ISD CAS 700, Energy Assistance Program, 11/13/1991.

ISD CAS 700, Energy Assistance Program, 11/10/1992.

ISD/CACB/LHP 700, Low Income

Home Energy Assistance Program, 5/6/1994.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 7/28/1994.

History of Repealed Material: 8.150.520 NMAC - Income (filed 9/17/2001), Repealed effective 7/1/2024.

Other: 8.150.520 NMAC - Income (filed 9/17/2001), Replaced by 8.150.520 NMAC - Income effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 150 LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
PART 600 DESCRIPTION OF PROGRAM/BENEFITS

8.150.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.150.600.1 NMAC - Rp 8.150.600.1 NMAC, 7/1/2024]

8.150.600.2 SCOPE: The rule applies to the general public.
[8.150.600.2 NMAC - Rp 8.150.600.2 NMAC, 7/1/2024]

8.150.600.3 STATUTORY AUTHORITY: Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. It also provides for administration of public assistance programs.
[8.150.600.3 NMAC - Rp 8.150.600.3 NMAC, 7/1/2024]

8.150.600.4 DURATION: Permanent.
[8.150.600.4 NMAC - Rp 8.150.600.4 NMAC, 7/1/2024]

8.150.600.5 EFFECTIVE DATE: July1, 2024, unless a different date is at the end of a section.
[8.150.600.5 NMAC - Rp 8.150.600.5 NMAC, 7/1/2024]

8.150.600.6 OBJECTIVE: The objective of these regulations is to provide policy and procedures for the administration of the low income home energy assistance program (LIHEAP).
[8.150.600.6 NMAC - Rp 8.150.600.6 NMAC, 7/1/2024]

8.150.600.7 DEFINITIONS: [**RESERVED**]

8.150.600.8 BENEFITS - ISSUANCE AND USE AND VENDOR RESPONSIBILITIES:

A. Issuance of benefits: Benefits are issued in one of the following methods:

(1) recipient warrants: HCA issues benefits directly to recipients through recipient warrants when appropriate and only as a last resort;

(2) vendor payments: HCA issues benefits directly to the vendor;

(a) HCA will provide the account name and customer account number for the LIHEAP eligible household to the vendor specified by the household; the vendor will notify HCA of mismatches within a specified time frame;

(b) vendors who carry customer accounts will credit eligible households with the amount of the LIHEAP regular benefit no more than 30 days from the time of the payment; vendors who provide fuel on demand will provide fuel to eligible households equal to the amount of the LIHEAP regular benefit no more than 30 days from the date of the eligible household's contact with the vendor to make arrangements for the provision of such fuel;

(c) vendors shall return to the LIHEAP central office excess LIHEAP benefits from the account originally credited if that account is closed.

(d) vendors should transfer a LIHEAP benefit credit on an account that is closed after the credit is posted; the transfer must be to a new or existing account for the new residence of the recipient household; the vendor must document the transfer in a manner that meets generally accepted audit standards;

(e) vendors may refund LIHEAP benefit credit to a household under certain circumstances when the household moves or will not have service with the company at their residence; the vendor must document the transfer in a manner that meets generally accepted audit standards;

(f) vendors must refund LIHEAP benefit credits on closed accounts to HCA when the credit cannot be transferred to a new account or the household cannot be located.

B. Benefit use: The recipient household which receives a direct payment is responsible for using the benefit for the purpose intended:

(1) to purchase fuel, such as propane, wood, coal, kerosene, fuel oil or other unregulated fuels;

(2) to pay the household's utility charges, such as those for electric or natural gas services;

(3) to purchase gasoline or tools needed when a household gathers/cuts its own firewood;

(4) to pay a landlord for the utility costs that are included in the rent payment;

(5) to pay for a deposit obligation needed to initiate or continue service.
[8.150.600.8 NMAC - Rp 8.150.600.8 NMAC, 7/1/2024]

8.150.600.9 STATE LIHEAP FUNDING:

A. Purpose: To reduce the home heating and cooling costs of low-income New Mexicans.

B. Benefits:

(1) payments that assist low-income households

to reduce the costs of home heating/ cooling; or

(2) weatherization services for the homes of low-income households.

[8.150.600.9 NMAC - Rp 8.150.600.9 NMAC, 7/1/2024]

8.150.600.10 FUND USES: Unless specified by the New Mexico state legislature, the secretary of the HCA has the authority to specify the uses of the funding. Funding will be used for purposes similar to those allowed under the federal low income home energy assistance program.

[8.150.600.10 NMAC - Rp 8.150.600.10 NMAC, 7/1/2024]

8.150.600.11 WINTER MORATORIUM ON UTILITY DISCONNECTION: No utility vendor regulated by the public regulation commission shall discontinue or disconnect residential utility service for heating from November 15 through March 15 of the subsequent year for certain customers.

A. Administering authority: The HCA or a tribal entity that administers its own low income home energy assistance program are designated as the authorities to identify customers who meet the certain qualifications for the winter moratorium. The customer must also meet the New Mexico public regulation commission requirements to receive winter moratorium protection.

B. Qualification: Customers who qualify for the winter moratorium must meet the following income standards:

(1) the customer is a member of a household in which the total gross income is at or below one hundred fifty percent of the current federal poverty guidelines; or

(2) one or more of the household members:

(a) receive supplemental security income; or

(b) are eligible for any federally funded assistance program administered by ISD with income guidelines at or below one hundred fifty percent of the current federal poverty guidelines;

(3) the person in whose name a utility account is listed and the name of the public assistance recipient need not match in order for the customer to be entitled to protection under this section.

C. Proof of qualification:

(1) HCA generated approval notice for public assistance programs whose income guidelines are at or below one hundred fifty percent of the current federal poverty guidelines;

(2) computer generated notice from HCA; or

(3) form completed by hand from a local ISD office.

[8.150.600.11 NMAC - Rp 8.150.600.11 NMAC, 7/1/2024]

HISTORY OF 8.150.600 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD 600.0000, Energy Assistance Programs, 11/12/1982.
ISD 600.0000, Low Income Energy Assistance Program, 1/9/1984.
ISD 710.0000, Energy Assistance Programs, 11/15/1985.
ISD 620.0000, Crisis Intervention Assistance, 11/12/1982.
ISD 620.0000, Energy Crisis Intervention Assistance, 12/27/1983.
ISD 714.0000, Energy Crisis Intervention, 11-20-85.
ISD 630.0000, Program Administration, 11/12/1982.
ISD 630.0000, Program Administration, 12/27/1983.
ISD 715.0000, Administration of Energy Assistance Programs, 11/20/1985.
ISD FA 710, Energy Assistance Programs, 12/5/1989.
ISD CAS 700, Energy Assistance Program, 11/13/1991.
ISD CAS 700, Energy Assistance Program, 11/10/1992.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 5/6/1994.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 7/28/1994.

History of Repealed Material: 8.150.600 NMAC - Description Of Program/Benefits (filed 9/17/2001), Repealed effective 7/1/2024.

Other: 8.150.600 NMAC - Description Of Program/Benefits (filed 9/17/2001), Replaced by 8.150.600 NMAC - Description Of Program/Benefits, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 150 LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
PART 620 BENEFIT DETERMINATION GENERAL

8.150.620.1 ISSUING AGENCY: New Mexico Health Care Authority.

[8.150.620.1 NMAC - Rp 8.150.620.1 NMAC, 7/1/2024]

8.150.620.2 SCOPE: The rule applies to the general public.

[8.150.620.2 NMAC - Rp 8.150.620.2 NMAC, 7/1/2024]

8.150.620.3 STATUTORY AUTHORITY: Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. It also provides for administration of public assistance programs.

[8.150.620.3 NMAC - Rp 8.150.620.3 NMAC, 7/1/2024]

8.150.620.4 DURATION: Permanent.

[8.150.620.4 NMAC - Rp 8.150.620.4 NMAC, 7/1/2024]

8.150.620.5 EFFECTIVE DATE: July 1, 2024, unless a

different date is at the end of a section.
[8.150.620.5 NMAC - Rp 8.150.620.5 NMAC, 7/1/2024]

8.150.620.6 OBJECTIVE: The objective of these regulations is to provide policy and procedures for the administration of the low income home energy assistance program (LIHEAP).
[8.150.620.6 NMAC - Rp 8.150.620.6 NMAC, 7/1/2024]

8.150.620.7 DEFINITIONS: [**RESERVED**]

8.150.620.8 POINT SYSTEM: A point allocation system is used to ensure that the highest level of assistance is provided to those households with the highest energy needs, lowest income and largest household member size while giving priority to those households with vulnerable members.
[8.150.620.8 NMAC - Rp 8.150.620.8 NMAC, 7/1/2024]

8.150.620.9 CALCULATING THE BENEFIT/ASSIGNMENT OF POINTS: To determine the amount of the benefit for households with an energy cost, HCA assigns points for each following factors.

A. Energy costs points: Points are assigned based on the energy burden at the household's current residence for households that have a direct cost for heating or cooling expenses.

(1) Energy burden: Energy burden is "the expenditures of the household for home energy divided by the income of the household." Points are assigned to the household by determining the households' percentage of energy burden. The point allocation for energy burden is:

(a) Zero points for zero to five percent energy burden;

(b) One point for six to ten percent energy burden;

(c) Two points for eleven to fifteen percent energy burden; or

(d) Three points for sixteen percent or more energy burden.

(2) Additional energy burden: If the household's energy burden is for the use of propane, an additional two points will be allocated.

(3) Receipt of energy burden points: Certain households do not receive energy burden points:

(a) households whose utilities are included in the rent; or

(b) households that use wood to heat their home and do not purchase wood.

(4) Energy standard allowance (ESA): Each year an ESA will be determined. The standard amount will be based on the fuel and electricity standards calculated for the standard utility allowance (SUA) used in the New Mexico supplemental nutrition assistance program (SNAP). The ESA may be used when the monthly utility costs provided by the applicant are: a) less than the standard; or b) the applicant has new service and costs are not available.

B. Income points: HCA assigns income points using the household's monthly total countable gross income and the household size. The number of points is determined by identifying what percentage the household's income is of the federal poverty guidelines (FPG) for the LIHEAP FFY. For example, if the total monthly income is sixty percent of the FPG, the household will receive three income points. (See below.)

(1) Three points - income is zero to one hundred percent of the FPG

(2) Two points - income is one hundred to one hundred fifty percent of the FPG

C. Vulnerable population points: HCA assigns additional points for any household members in the following vulnerable groups.

(1) Age 60 and over: Two points are assigned to eligible households based on the inclusion of one or more household members age 60 or over as determined by birthdate data.

(2) Age five and under: Two points are assigned to eligible households based on the inclusion of one or more household members age five and under as determined by birthdate data.

(3) Disability: Two points are assigned to eligible households having one or more members with a disability. Disability is defined as physical or mental impairment resulting in substantial reduction in the ability of an individual to care for themselves or carry out normal activities. When one or more members receive disability based income, the household is entitled to the points. A doctor's statement of current disability will be required for assignment of the point for this factor if the disabled member does not receive disability-based income.
[8.150.620.9 NMAC - Rp 8.150.620.9 NMAC, 7/1/2024]

8.150.620.10 CALCULATION OF BENEFIT AMOUNT:

A. Prior to the start of the application period projections will be made to determine point value. Anticipated grant of award, potential applicants and the current economy of the state of New Mexico will be used to determine the point value. Households eligible for a LIHEAP benefit will have their point total multiplied times the point value. The product is the amount of payment that is issued to the utility vendor for credit on the household's account or is sent to the household.

B. Based on the availability of funds, benefits are issued for eligible applications received through September 30.

C. At the direction of the HCA secretary, the point value for energy cost points, income points, vulnerable population points, additional energy burden points, or any of their parts, may be adjusted as necessary taking into consideration the factors described in Subsection A of 8.150.620.10 NMAC.

[8.150.620.10 NMAC - Rp 8.150.620.10 NMAC, 7/1/2024]

8.150.620.11 [Reserved]
[8.150.620.11 NMAC - Rp 8.150.620.11 NMAC, 7/1/2024]

8.150.620.12 RETROACTIVE BENEFIT COVERAGE: Households that were denied LIHEAP benefits or received a lesser benefit than they were entitled to but prevail in an appeal through an agency conference or fair hearing are entitled a retroactive benefit.
[8.150.620.12 NMAC - Rp 8.150.620.12 NMAC, 7/1/2024]

HISTORY OF 8.150.620 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD 600.0000, Energy Assistance Programs, 11/12/1982.
ISD 600.0000, Low Income Energy Assistance Program, 1/9/1984.
ISD 710.0000, Energy Assistance Programs, 11/15/1985.
ISD 620.0000, Crisis Intervention Assistance, 11/12/1982.
ISD 620.0000, Energy Crisis Intervention Assistance, 12/27/1983.
ISD 714.0000, Energy Crisis Intervention, 11/20/1985.
ISD 630.0000, Program Administration, 11/12/1982.
ISD 630.0000, Program Administration, 12/27/1983.
ISD 715.0000, Administration of Energy Assistance Programs, 11/20/1985.
ISD FA 710, Energy Assistance Programs, 12/5/1989.
ISD CAS 700, Energy Assistance Program, 11/13/1991.
ISD CAS 700, Energy Assistance Program, 11/10/1992.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 5/6/1994.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 7/28/1994.

History of Repealed Material:
8.150.620 NMAC - Benefit Determination General (filed 9/17/2001), Repealed effective 7/1/2024.

Other: 8.150.620 NMAC - Benefit Determination General (filed 9/17/2001), Replaced by 8.150.620 NMAC - Benefit Determination General, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 150 LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
PART 624 RETROACTIVE BENEFIT COVERAGE

8.150.624.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.150.624.1 NMAC - Rp 8.150.624.1 NMAC, 7/1/2024]

8.150.624.2 SCOPE: The rule applies to the general public.
[8.150.624.2 NMAC - Rp 8.150.624.2 NMAC, 7/1/2024]

8.150.624.3 STATUTORY AUTHORITY: Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. It also provides for administration of public assistance programs.
[8.150.624.3 NMAC - Rp 8.150.624.3 NMAC, 7/1/2024]

8.150.624.4 DURATION: Permanent.
[8.150.624.4 NMAC - Rp 8.150.624.4 NMAC, 7/1/2024]

8.150.624.5 EFFECTIVE DATE: July1, 2024, unless a different date is at the end of a section.
[8.150.624.5 NMAC - Rp 8.150.624.5 NMAC, 7/1/2024]

8.150.624.6 OBJECTIVE: The objective of these regulations is to provide policy and procedures for the administration of the low income home energy assistance program (LIHEAP).
[8.150.624.6 NMAC - Rp 8.150.624.6 NMAC, 7/1/2024]

8.150.624.7 DEFINITIONS: [RESERVED]

8.150.624.8 RETROACTIVE BENEFIT COVERAGE: Households that were denied LIHEAP benefits or received a lesser benefit than they were entitled to but, as the result of an agency conference or fair hearing, are determined to be entitled to a benefit will be issued a retroactive benefit.
[8.150.624.8 NMAC - Rp 8.150.624.8 NMAC, 7/1/2024]

HISTORY OF 8.150.624 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD 600.0000, Energy Assistance Programs, 11/12/1982.
ISD 600.0000, Low Income Energy Assistance Program, 1/9/1984.
ISD 710.0000, Energy Assistance Programs, 11/15/1985.
ISD 620.0000, Crisis Intervention Assistance, 11/12/1982.
ISD 620.0000, Energy Crisis Intervention Assistance, 12/27/1983.
ISD 714.0000, Energy Crisis Intervention, 11/20/1985.
ISD 630.0000, Program Administration, 11/12/1982.
ISD 630.0000, Program Administration, 12/27/1983.
ISD 715.0000, Administration of Energy Assistance Programs, 11/20/1985.
ISD FA 710, Energy Assistance Programs, 12/5/1989.
ISD CAS 700, Energy Assistance Program, 11/13/1991.
ISD CAS 700, Energy Assistance Program, 11/10/1992.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 5/6/1994.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program,

7/28/1994.

History of Repealed Material: 8.150.624 NMAC - Retroactive Benefit Coverage (filed 9/17/2001), Repealed effective 7/1/2024.

Other: 8.150.624 NMAC - Retroactive Benefit Coverage (filed 9/17/2001), Replaced by 8.150.624 NMAC - Retroactive Benefit Coverage, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 200 MEDICAID ELIGIBILITY - GENERAL RECIPIENT RULES
PART 450 REPORTING REQUIREMENTS

8.200.450.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.200.450.1 NMAC - Rp 8.200.450.1 NMAC, 7/1/2024]

8.200.450.2 SCOPE: The rule applies to the general public.
[8.200.450.2 NMAC - Rp 8.200.450.2 NMAC, 7/1/2024]

8.200.450.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 NMSA 1978 et. seq. (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.200.450.3 NMAC - Rp 8.200.450.3 NMAC, 7/1/2024]

8.200.450.4 DURATION: Permanent.
[8.200.450.4 NMAC - Rp 8.200.450.4 NMAC, 7/1/2024]

8.200.450.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.200.450.5 NMAC - Rp 8.200.450.5 NMAC, 7/1/2024]

8.200.450.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.200.450.6 NMAC - Rp 8.200.450.6 NMAC, 7/1/2024]

8.200.450.7 DEFINITIONS [**RESERVED**]

8.200.450.8 MISSION: To 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.
[8.200.450.8 NMAC - Rp 8.200.450.8 NMAC, 7/1/2024]

8.200.450.9 REPORTING REQUIREMENTS: A medicaid applicant/recipient must report any change in circumstances which might affect their eligibility within 10 days after the change to the local income support division (ISD) office. This provision does not apply to children's medicaid (category of eligibility 032). See 8.232.600.14 NMAC, *changes in eligibility*.
[8.200.450.9 NMAC - Rp 8.200.450.9 NMAC, 7/1/2024]

HISTORY OF 8.200.450 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:
8 NMAC 4.MAD.430, Recipient Policies, Recipient Rights and Responsibilities, 12/30/1994.

History of Repealed Material: 8.200.450 NMAC - Reporting Requirements (filed 12/18/2000) Repealed effective 7/1/2024.

Other: 8.200.450 NMAC - Reporting Requirements (filed 12/18/2000) Replaced by 8.200.450 NMAC - Reporting Requirements effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 201 MEDICAID ELIGIBILITY - MEDICAID EXTENSION (CATEGORY 01, 03 and 04)
PART 500 INCOME AND RESOURCE STANDARDS

8.201.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.201.500.1 NMAC - Rp 8.201.500.1 NMAC 7/1/2024]

8.201.500.2 SCOPE: The rule applies to the general public.
[8.201.500.2 NMAC - Rp 8.201.500.2 NMAC 7/1/2024]

8.201.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.201.500.3 NMAC - Rp 8.201.500.3 NMAC 7/1/2024]

8.201.500.4 DURATION: Permanent.
[8.201.500.4 NMAC - Rp 8.201.500.4 NMAC 7/1/2024]

8.201.500.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.201.500.5 NMAC - Rp 8.201.500.5 NMAC 7/1/2024]

8.201.500.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.201.500.6 NMAC - Rp 8.201.500.6 NMAC 7/1/2024]

8.201.500.7 DEFINITIONS: [**RESERVED**]

8.201.500.8 [**RESERVED**]

8.201.500.9 NEED DETERMINATION: [RESERVED]
[8.201.500.9 NMAC - Rp 8.201.500.9 NMAC 7/1/2024]

8.201.500.10 RESOURCE STANDARDS: To be eligible for medicaid extension, applicants/ recipients must meet SSI resource standards. Recipients initially eligible for medicaid extension under E01 status lose eligibility when their resources exceed the SSI resource maximum. See 8.215.500.11 NMAC, *resource standards,* for information on exclusions, disregards, and countable resources.
[8.201.500.10 NMAC - Rp 8.201.500.10 NMAC 7/1/2024]

8.201.500.11 RESOURCE TRANSFERS: The social security administration excluded transfer of resources as a factor of eligibility for non-institutionalized SSI recipients. Transfer of resources is not a factor for consideration in categories that use SSI methodology in the eligibility determination.
[8.201.500.11 NMAC - Rp 8.201.500.11 NMAC 7/1/2024]

8.201.500.12 TRUSTS: See 8.281.510 NMAC and following subsections.
[8.201.500.12 NMAC - Rp 8.201.500.12 NMAC 7/1/2024]

8.201.500.13 INCOME STANDARDS: To be eligible for medicaid extension, an applicant/ recipient must have countable income below the SSI FBR. See 8.215.500.18 NMAC, *income,* through 8.215.500.22 NMAC, *disregards*, for information on exclusions, disregards, and countable income.
[8.201.500.13 NMAC - Rp 8.201.500.13 NMAC 7/1/2024]

8.201.500.14 COMPUTATION OF COLA DISREGARDS IN PICKLE AND 503 LEADS CASES:

A. An applicant/ recipient's countable income, after exclusion of the Title II COLAs received following SSI termination, must be less than the current SSI federal benefit rate (FBR).

B. To determine the total amount of the applicant/ recipient's Title II COLAs received since the applicant/recipient lost SSI, the following calculation must be completed:

(1) divide the current Title II amount by the percentage amount of the previous year's COLA;

(2) repeat this calculation for each Title II COLA benefit received after the applicant lost SSI; computations are based on the previous year's COLA and previous benefit; see 8.200.520.12 NMAC, *COLA disregard computation*, of 503 leads and pickle cases;

(3) when the last computation is completed, the result is the Title II benefit amount the applicant/ recipient was receiving when they lost SSI;

(4) subtract this amount from the current Title II benefit amount; the result is the aggregate Title II COLAs the applicant/recipient received after losing SSI; and

(5) subtract the aggregate COLAs from the applicant/recipient's countable income to determine if the income is below the current SSI FBR.

C. If the resulting income is below the current SSI FBR, and the applicant/recipient meets all other requirements for SSI, they are eligible for medicaid extension.
[8.201.500.14 NMAC - Rp 8.201.500.14 NMAC 7/1/2024]

8.201.500.15 DEEMED INCOME: If an applicant/recipient is a minor who lives with a parent(s), deemed income from the parent(s) must be considered. If an applicant/ recipient is married and lives with a spouse, deemed income from the spouse must be considered. See 8.215.500.21 NMAC, *deemed income*, for information on deemed income. If an applicant/recipient has a spouse or parent who receives Title II benefits, all COLAs received by the spouse/parent since the applicant/ recipient lost SSI are deducted from the spouse/parent's income before it is deemed to the applicant/recipient.
[8.201.500.15 NMAC - Rp 8.201.500.15 NMAC 7/1/2024]

8.201.500.16 [**RESERVED**]
[8.201.500.16 NMAC - Rp 8.201.500.16 NMAC 7/1/2024]

HISTORY OF 8.201.500 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 370.0000, Procedures for Retroactive Supplemental Security Income (SSI) Medicaid and Medicaid Extension, filed 5/26/1980.
ISD 370.0000, Procedures for Retroactive Supplemental Security Income (SSI) Medicaid and Medicaid Extension, filed 1/26/1982.
MAD Rule 370.0000, Procedures for Retroactive Supplemental Security Income (SSI) Medicaid and Medicaid Extension, filed 12/1/1987.
MAD Rule 870, Retroactive Medicaid Coverage, filed 1/31/1990.
MAD Rule 870, Retroactive Medicaid Coverage, filed 3/11/1992.
MAD Rule 870, Retroactive Medicaid Coverage, filed 11/16/1994.
MAD Rule 372.0000, Medicaid Extension, 12/1/1987.
MAD Rule 872, Medicaid Extension, filed 1/31/1990.
MAD Rule 872, Medicaid Extension, filed 3/11/1992.
MAD Rule 872, Medicaid Extension, filed 8/20/1992.

MAD Rule 872, Medicaid Extension, filed 9/26/1994.

History of Repealed Material:
MAD Rule 872, Medicaid Extension, filed 9/26/1994 - Repealed effective 2/1/1995.
8.201.500 NMAC - Income And Resource Standards (filed 9/2/2009), Repealed effective 7/1/2024.

Other: 8.201.500 NMAC - Income And Resource Standards (filed 9/2/2009), Replaced by 8.201.500 NMAC - Income And Resource Standards effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 206 MEDICAID ELIGIBILITY - CYFD CHILDREN (CATEGORIES 006, 017, 037, 046, 047, 060, 061, 066 & 086)
PART 500 INCOME AND RESOURCE STANDARDS

8.206.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.206.500.1 NMAC - Rp 8.206.500.1 NMAC, 7/1/2024]

8.206.500.2 SCOPE: This rule applies to the general public.
[8.206.500.2 NMAC - Rp 8.206.500.2 NMAC, 7/1/2024]

8.206.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.206.500.3 NMAC - Rp 8.206.500.3 NMAC, 7/1/2024]

8.206.500.4 DURATION: Permanent.
[8.206.500.4 NMAC - Rp 8.206.500.4 NMAC, 7/1/2024]

8.206.500.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.206.500.5 NMAC - Rp 8.206.500.5 NMAC, 7/1/2024]

8.206.500.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.206.500.6 NMAC - Rp 8.206.500.6 NMAC, 7/1/2024]

8.206.500.7 DEFINITIONS: [**RESERVED**]

8.206.500.8 [**RESERVED**]

8.206.500.9 [RESERVED]

8.206.500.10 RESOURCE STANDARDS: To be eligible for CYFD medicaid, the value of all countable personal and real property, considered belonging to or available to an applicant/recipient under 18 years of age or 21 years of age in expanded foster care medicaid category 006 or 066 cannot exceed $1,000. If an applicant/recipient owns resource or saving in excess of this amount, they are not eligible for CYFD medicaid.
[8.206.500.10 NMAC - Rp 8.206.500.10 NMAC, 7/1/2024]

8.206.500.11 APPLICABLE RESOURCE STANDARDS: The authorized representative from CYFD who completes the application on behalf of the applicant/recipient must initiate all appropriate steps to make available property or resources to which the applicant/recipient may be entitled. Normally, individuals under 18 do not own/control property. Property that is held or controlled on behalf of an applicant/recipient is considered available unless some specific provision in the title to the property precludes it availability.

A. Property not readily marketable: Even property that is not marketable must be assessed in the eligibility determination and is subject to transfer restrictions and penalties.

B. Property share owned: The current value of property which must be partitioned to be accessible is not considered available if the net value after estimated costs of partition and other closing costs is less than the resource limit. If the amount likely to be derived from the sale of the applicant/recipient's share of the property exceeds the resource limit, they must initiate attempts to obtain their share of the property.

C. Property owned by parent: The value of property owned by the parent who does not live with the applicant/recipient is not considered available to the applicant/recipient.
[8.206.500.11 NMAC - Rp 8.206.500.11 NMAC, 7/1/2024]

8.206.500.12 COUNTABLE RESOURCES: Countable resources include but are not limited to the following:

A. cash value of life insurance policy owned by the applicant/recipient;

B. cash, bank accounts and other readily negotiable assets owned by the applicant/recipient are countable resources;

C. equipment, tools, and motor vehicles (which do not fit the vehicle exemption);

D. livestock; and

E. asset conversion; money received from one-time or sporadic sales of real or personal property such as crops, rugs, or jewelry is considered a resource if the property is not sold or transferred in connection with a business of self-employment activity.

(1) Actual verified expenses associated with the purchase, sale, or production of the property are deducted from money received from the sale to arrive at the net resource value.

(2) Property converted into money is subject to the resource limitation regardless of whether it was fully or partially exempt prior to conversion.
[8.206.500.12 NMAC - Rp 8.206.500.12 NMAC, 7/1/2024]

8.206.500.13 RESOURCE EXCLUSIONS: Certain resources are excluded from the resource computation.

A. Vehicle exclusion: The equity value of one vehicle belonging to the applicant/recipient or in their name, is not considered a countable resource if the value of the vehicle is $1,500 or less. Any excess over $1,500 is a countable resource. The value of any apparatus for the handicapped which is installed on the vehicle is also excluded.

B. Income exclusion: Any income which is excluded under income provisions is also excluded from consideration as a resource. Excluded income which is saved must be kept separate from non-excluded savings.

C. Settlement fund payment exclusion: Payments received from the Radiation Exposure Compensation Act is excluded. Payments made under the Agent Orange Settlement Act is also excluded. Payments by the remembrance, responsibility and the future foundation to individual survivors forced into slave labor by the Nazis are excluded.

D. Earned income tax credit payment exclusion: Earned income tax credit payments are not considered resources until the third month after receipt of the payment.

E. Funeral agreement exclusion: The equity value of funeral agreement(s) owned by the applicant/recipients which do not exceed $1,500 are excluded.

F. Contingent and unliquidated claim exclusion: "Contingent and unliquidated claim" is defined as a yet unnamed right of the applicant/recipient to receive, at some future time, a resource such as an interest in an unprobated estate or damages/compensation from an accident or injury. These claims are excluded if the applicant/recipient can demonstrate that they have consulted an attorney or that under the circumstances it is reasonable not to have consulted an attorney but that they are making effort to prosecute their claim or to proceed with the probate. If the applicant/recipient can demonstrate that their share in an unprobated estate would be less than the expense of the proceeding to probate the estate, the value is not considered a resource.

G. Chafee medicaid: All resources belonging to recipients of chafee medicaid who are between 18 and 21 years of age are excluded.
[8.206.500.13 NMAC - Rp 8.206.500.13 NMAC, 7/1/2024]

8.206.500.14 RESOURCE TRANSFERS: To be eligible for CYFD Medicaid, the applicant/recipient must not have transferred resources within two years prior to application for the purpose of qualifying for CYFD medicaid. An applicant/recipient under eighteen years of age cannot transfer property, except through a guardian. Normally, such applicants/recipients do not own property in their own right. If facts indicate the existences of a trust, inheritance, or prior gift, the CYFD representative completing the application must determine if a transfer has taken place within the two year period.

A. Transfers made for the purpose of qualifying for medicaid: A transfer is considered to have been made for the purpose of becoming eligible if:

(1) the transfer was made without a reasonable return; and

(2) the applicant/recipient had no reasonable plan for support at the time of the transfer other than receiving CYFD medicaid.

(3) if the value of the applicant/recipient's equity in the transferred property plus all other countable resources is less than $1,000, the transfer is not considered to be for the purpose of becoming eligible.

B. Definitions:

(1) "Transfer" includes the sale, transfer by gift, or conveyance by deed or any other method of transferring the title to the property. The transfer can be for either the title to real property or any other interest or rights in real property, such as mineral rights.

(2) "Reasonable return" is considered to have been received when the applicant/recipient received compensation in cash or in kind equals the value of the property at the time of transfer. This determination is based on the applicant/recipient's equity interest in the property at the time of transfer.

C. Attempts to obtain reasonable return: If the property was transferred for the purpose of becoming eligible but the applicant/recipient subsequently makes and continues to make efforts to obtain a reasonable return or regain the title, the applicant/recipient is not ineligible because of the improper transfer of resources.

D. Period of ineligibility: If a transfer without fair return was made for the purpose of becoming eligible for CYFD Medicaid, the applicant/recipient is ineligible for a period of 24 months beginning with the month the resources were transferred.
[8.206.500.14 NMAC - Rp 8.206.500.14 NMAC, 7/1/2024]

8.206.500.15 TRUSTS: If an applicant/recipient is the beneficiary of a trust fund, a copy of the trust document and any other documents pertaining to the creation of the trust must be submitted to the eligibility unit of the medical assistance division for coordination of the trust analysis with the HCA's office of general counsel.
[8.206.500.15 NMAC - Rp 8.206.500.15 NMAC, 7/1/2024]

8.206.500.16 INCOME STANDARDS:

A. To be eligible

for CYFD medicaid, the applicant/recipient's income must be less than the maximum aid to families with dependent children (AFDC) standard for one person. See 8.200.520.10 NMAC, *Income Standards*. Any earned and unearned income that belongs to the applicant/recipient must be totaled and compared to the standard.

B. The authorized representative of CYFD who completes the medicaid application on behalf of the applicant/recipient must take all necessary steps to apply for or obtain any other income which the applicant/recipient may qualify for when the individual becomes aware of the income. If income becomes available to the applicant/recipient, their eligibility for CYFD medicaid must be re-evaluated.

C. Sources of potential income include social security, veterans benefits, supplement security income, trust funds, and contingent claims.

[8.206.500.16 NMAC - Rp 8.206.500.16 NMAC, 7/1/2024]

8.206.500.17 EARNED INCOME:

A. If an applicant/recipient of CYFD medicaid has earned income and is not a full-time student in elementary school, high school, or a course of vocational or technical training, their earnings are considered in the earned income calculation.

B. Earned income exclusions:

(1) Exclusion for full-time students: If an applicant/recipient of CYFD medicaid has earned income and is a full-time student in elementary school, high school, or in a course of vocational or technical training, their earnings are totally excluded.

(2) Job Training Partnership Act (JTPA) earnings and earned income tax credit exclusion: JTPA earning/reimbursement and earned income tax credit payments are excluded from consideration as income regardless of whether the applicant/recipient is a full-time student.

(3) Work-related expense disregard: An applicant/recipient of CYFD medicaid with earned income from employment is entitled to a deduction of $90 from gross monthly earnings for work-related expenses.

(4) Census bureau employment: Wages paid by the census bureau for temporary employment related to the census are excluded from consideration as income in the eligibility determination process.

(5) Recipients of Chafee medicaid: All earned income of an applicant/recipient between 18 and 21 years of age is excluded while receiving chafee independent living assistance from CYFD.

[8.206.500.17 NMAC - Rp 8.206.500.17 NMAC, 7/1/2024]

8.206.500.18 UNEARNED INCOME: Unearned incomes includes but is not limited to social security benefits, child support, gifts, contributions, and all other cash income which does not meet the definition of earned income. Unearned income is counted in the gross amount received.

A. Unearned income exclusions and disregards: Certain amounts of unearned income are excluded from the computation of unearned income.

(1) Educational assistance exclusions: Bona fide loans from private individuals or commercial institutions for education assistance are excluded from unearned income. Income from work study whose purpose is to assist with educational expenses are excluded from unearned income. Educational grants and scholarships whose purpose is to assist with education expenses are excluded regardless of the actual utilization of the funds.

(2) Child nutrition and school lunch benefit exclusion: Child nutritional and school lunch benefits provided in the form of money payments, vouchers, or foodstuffs authorized under the Child Nutritional Act and the National School Lunch Act are excluded.

(3) Income tax return income exclusion: State and federal income tax refunds are excluded from consideration as income. Tax refunds are considered resources.

(4) Native American payment exclusion: Certain payments to Native Americans can be excluded which include:

(a) per capita payment of tribal funds authorized by the tribe or by the secretary of the United States department of the interior; payments received and distributed by the bureau of Indian affairs (BIA) as a trustee for an individual members of a tribe, refer to as individual Indian monies (IAMB) are not considered as per capita payments;

(b) interest derived from retrained per capita payments is disregarded if the retained per capita payments have not been commingled with other savings; and

(c) BIA general assistance payments made to disabled tribal members by the BIA;

(d) any tax exempt payment made under the Alaska Native Claims Act are excluded from consideration as unearned income.

(5) Settlement fund payment exclusions: Payments received from the agent orange settlement fund or from any other fund established pursuant to the agent orange product liability litigation settlement are excluded from unearned income. Payments received from the Radiation Exposure Compensation Act are excluded from unearned income. Payments by the remembrance, responsibility and the future foundation to individual survivors forced into slave labor by the Nazis are excluded from unearned income.

(6) Payments made by division of vocational rehabilitation: Any payment made by

the division of vocation rehabilitation to an applicant/recipient in training to help them meet additional training costs are disregarded. The entire payment is disregarded unless specific portion is designated for basic maintenance and the applicant/recipient is maintaining only one resident. The portion designated for basic maintenance is considered income.

(7) Child support disregard: The first $50 of child support payments received in a month from an absent parent which represents payment on a support obligation for the month is disregarded in the eligibility determination and redetermination process.

(a) If multiple child support payments are received such as cases where more than one parent is paying or a parent makes weekly or biweekly payments, the disregard is allowed only once during the month.

(b) If a payment included both current support and arrearage, the disregard is allowed only on the current support.

(8) Disregard for payments made by CYFD: Payment made by CYFD to a third party on behalf of an applicant/recipient are not considered income to the applicant/recipient.

(9) Chafee independent living assistance recipients: All unearned income of an applicant/recipient between 18 and 21 years of age is excluded.
[8.206.500.18 NMAC - Rp 8.206.500.18 NMAC, 7/1/2024]

8.206.500.19 DEEMED INCOME: Income is not deemed to an applicant/recipient from their parents if the applicant/recipient is the full or partial financial responsibility of CYFD. Any voluntary contributions made by the applicant/recipient's parent(s) is considered as unearned income.
[8.206.500.19 NMAC - Rp 8.206.500.19 NMAC, 7/1/2024]

8.206.500.20 TOTAL INCOME: The combination of the applicant/recipient's earned income and unearned income minus any applicable exclusions and disregards is compared to the maximum income standard for one person to determine if the applicant/recipient is eligible for CYFD medicaid.
[8.206.500.20 NMAC - Rp 8.206.500.20 NMAC, 7/1/2024]

8.206.500.21 LUMP SUM PAYMENTS: Lump sums are considered as income in the month received and resources (if retained) as of the first moment of the first day of the following month.
[8.206.500.21 NMAC - Rp 8.206.500.21 NMAC, 7/1/2024]

HISTORY OF 8.206.500 NMAC: [**RESERVED**]

History of Repealed Material: 8.206.500 NMAC - Income And Resource Standards (filed 12/15/2001), Repealed effective 7/1/2024.

Other: 8.206.500 NMAC - Income And Resource Standards (filed 12/15/2001), Replaced by 8.206.500 NMAC - Income And Resource Standards, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 206 MEDICAID ELIGIBILITY - CYFD CHILDREN (CATEGORIES 006, 017, 037, 046, 047, 060, 061, 066 and 086)
PART 600 BENEFIT DESCRIPTION

8.206.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.206.600.1 NMAC - Rp 8.206.600.1 NMAC, 7/1/2024]

8.206.600.2 SCOPE: The rule applies to the general public.
[8.206.600.2 NMAC - Rp 8.206.600.2 NMAC, 7/1/2024]

8.206.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.206.600.3 NMAC - Rp 8.206.600.3 NMAC, 7/1/2024]

8.206.600.4 DURATION: Permanent.
[8.206.600.4 NMAC - Rp 8.206.600.4 NMAC, 7/1/2024]

8.206.600.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.206.600.5 NMAC - Rp 8.206.600.5 NMAC, 7/1/2024]

8.206.600.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.206.600.6 NMAC - Rp 8.206.600.6 NMAC, 7/1/2024]

8.206.600.7 DEFINITIONS: [**RESERVED**]

8.206.600.8 [**RESERVED**]

8.206.600.9 BENEFIT DESCRIPTION: An applicant/recipient who is eligible for medicaid under this category is eligible to receive the full range of medicaid-covered services.
[8.206.600.9 NMAC - Rp 8.206.600.9 NMAC, 7/1/2024]

8.206.600.10 BENEFIT DETERMINATION:

A. A written signed application must be made for every approved CYFD medicaid case.

(1) For voluntary placements, the parent(s) or guardian(s) must complete and sign the application on behalf of the child.

(2) For involuntary placements, information should be obtained from the parents. The social worker from CYFD may complete and sign the application on behalf of the child.

B. Applications must be acted on within 45 days of the date of application.

[8.206.600.10 NMAC - Rp 8.206.600.10 NMAC, 7/1/2024]

8.206.600.11 INITIAL BENEFITS: Notice of approval or denial of the application for CYFD medicaid is prepared. If the applicant is ineligible, the denial notice contains the reason for denial and explanation of the applicant's right to request an administrative hearing.

[8.206.600.11 NMAC - Rp 8.206.600.11 NMAC, 7/1/2024]

8.206.600.12 ONGOING BENEFITS: A periodic review to re-establish eligibility for medicaid must be done every six months.

[8.206.600.12 NMAC - Rp 8.206.600.12 NMAC, 7/1/2024]

8.206.600.13 RETROACTIVE BENEFIT COVERAGE: Up to three months of retroactive medicaid coverage can be furnished to applicants who have received medicaid-covered services during the retroactive period and would have met applicable eligibility criteria had they applied during the three months prior to the month of application 42 CFR Section 435.914. Retroactive coverage is not available prior to January 1, 1995, to applicants/ recipients of Category 060 and 061.

A. Application for retroactive benefit coverage: Application for retroactive medicaid can be made by checking "yes" in the "application for retroactive medicaid payments" box on the application/ redetermination of eligibility for medicaid assistance (MAD 381) form or by checking "yes" to the question "Does anyone in your household have unpaid medical expenses in the last three months?" on the application for assistance (ISD 100 S) form. Applications for retroactive medicaid benefits must be made by 180 days from the date of application for assistance. Medicaid-covered services which were furnished more than two years prior to application are not covered.

B. Approval requirements: To establish retroactive eligibility, the ISS must verify that all conditions of eligibility were met for each of the three retroactive months and that the applicant received medicaid-covered services. Each month must be approved or denied on its own merits. Retroactive eligibility can be approved on either the ISD2 system (for categories programmed on that system) or on the retroactive medicaid eligibility authorization (ISD 333) form.

C. Notice:

(1) Notice to applicant: The applicant must be informed if any of the retroactive months are denied.

(2) Recipient responsibility to notify provider: After the retroactive eligibility has been established, the ISS must notify the recipient that they are responsible for informing all providers with outstanding bills of the retroactive eligibility determination. If the recipient does not inform all providers and furnish verification of eligibility which can be used for billing and the provider consequently does not submit the billing within 120 days from the date of approval of retroactive coverage, the recipient is responsible for payment of the bill.

[8.206.600.13 NMAC - Rp 8.206.600.13 NMAC, 7/1/2024]

8.206.600.14 CHANGES IN ELIGIBILITY: Case closure must be effective the month following the month the case ceases to meet any of the financial or non-financial eligibility requirements. Case closure information must be transmitted to the medicaid claims processing contractor within 30 days of closure.

[8.206.600.14 NMAC - Rp 8.206.600.14 NMAC, 7/1/2024]

HISTORY OF 8.206.600 NMAC: [**RESERVED**]

History of Repealed Material: 8.206.600 NMAC - Benefit Description (filed 9/13/2013) Repealed effective 7/1/2024.

Other: 8.206.600 NMAC - Benefit Description (filed 9/13/2013), Replaced by 8.206.600 NMAC - Benefit Description, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 240 MEDICAID ELIGIBILITY - QUALIFIED MEDICARE BENEFICIARIES (QMB) (CATEGORY 040)
PART 400 RECIPIENT POLICIES

8.240.400.1 ISSUING AGENCY: New Mexico Health Care Authority.

[8.240.400.1 NMAC - Rp 8.240.400.1 NMAC, 7/1/2024]

8.240.400.2 SCOPE: The rule applies to the general public.

[8.240.400.2 NMAC - Rp 8.240.400.2 NMAC, 7/1/2024]

8.240.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.240.400.3 NMAC - Rp 8.240.400.3 NMAC, 7/1/2024]

8.240.400.4 DURATION: Permanent.
[8.240.400.4 NMAC - Rp 8.240.400.4 NMAC, 7/1/2024]

8.240.400.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.240.400.5 NMAC - Rp 8.240.400.5 NMAC, 7/1/2024]

8.240.400.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.240.400.6 NMAC - Rp 8.240.400.6 NMAC, 7/1/2024]

8.240.400.7 DEFINITIONS: [**RESERVED**]

8.240.400.8 [**RESERVED**]

8.240.400.9 QUALIFIED MEDICARE BENEFICIARIES (QMB) - CATEGORY 040: To be eligible for the qualified medicare beneficiaries program (QMB), an applicant/recipient must be covered by medicare part A. Medicare part A is a free entitlement to social security beneficiaries who are 65 years of age or older or who have received social security disability payments for 24 months. Fully or currently insured workers, or their dependents, who have end-stage renal disease are also covered under medicare. Most applicants/recipients 65 years of age or older who do not receive free medicare part A can voluntarily enroll for hospital insurance coverage, with payment of a monthly premium. Voluntary enrollees must also enroll for supplementary medical insurance, medicare part B, and pay that premium, as well.
[8.240.400.9 NMAC - Rp 8.240.400.9 NMAC, 7/1/2024]

8.240.400.10 BASIS FOR DEFINING THE GROUP: Applicants/recipients eligible for medicaid coverage under any other category may be eligible for coverage under QMB. QMB eligibility affords two advantages when an applicant/recipient is already eligible for medicaid:

A. medicare premium part A is payable by medicaid; and

B. medicaid receives federal matching funds for purchase of medicare part B.
[8.240.400.10 NMAC - Rp 8.240.400.10 NMAC, 7/1/2024]

8.240.400.11 GENERAL RECIPIENT REQUIREMENTS: [RESERVE]
[8.240.400.11 NMAC - Rp 8.240.400.11 NMAC, 7/1/2024]

8.240.400.12 ENUMERATION: Applicants/recipients must furnish their social security account number(s). QMB eligibility is denied or terminated if applicants/recipients fail to furnish their social security numbers.
[8.240.400.12 NMAC - Rp 8.240.400.12 NMAC, 7/1/2024]

8.240.400.13 CITIZENSHIP:

A. Refer to medical assistance program manual 8.200.410.11 NMAC.

B. Verification of citizenship: Citizenship determinations rendered by the social security administration (SSA) for SSI are final.

(1) Documentation of citizenship: Primary documentation of citizenship is a birth certificate. Secondary documentation includes:

(a) certificate of naturalization;

(b) citizenship certificate;

(c) other resident identification documents issued by the United States immigration and naturalization service, such as:

(i) U.S. passport issued by the U.S. state department;

(ii) consular report of birth;

(iii) certification of birth issued by the U.S. state department, proof of marriage to a U.S. citizen before September 2, 1922, or a card of identity and registration of a U.S. citizen; or

(iv) official communication from an American foreign service post indicating that an applicant/recipient is registered as a United States citizen.

(2) Declaration of citizenship, nationality, or immigration status: As a condition of eligibility, medicaid requires a declaration by the applicant/recipient or by another person on behalf of a child or an applicant/recipient who is mentally incapacitated, which specifies whether the applicant/recipient is a citizen or national of the United States. If not, the declaration must state that the applicant/recipient is in satisfactory immigration status. Eligibility is not denied solely because an applicant/recipient cannot legally sign the declaration and the individual who is legally able to do so refuses to sign on the applicant/recipient's behalf or to cooperate, as required.
[8.240.400.13 NMAC - Rp 8.240.400.13 NMAC, 7/1/2024]

8.240.400.14 RESIDENCE: An applicant/recipient must be physically present in New Mexico on the date of application or final determination of eligibility and have demonstrated intent to remain in the state. If the applicant/recipient does not have the present mental capacity to declare intent, the parent, guardian or adult child can assume responsibility for a declaration of intent. If there is no guardian or relative to assume responsibility for a declaration of intent, the state where the applicant/recipient is living is recognized as the state of residence. A temporary absence from the state does not prevent eligibility. A temporary absence exists if an applicant/recipient leaves the state for a specific purpose with a time-limited goal and intends to return to New Mexico when the purpose is accomplished.
[8.240.400.14 NMAC - Rp

8.240.400.14 NMAC, 7/1/2024]

8.240.400.15 NONCONCURRENT RECEIPT OF ASSISTANCE: A QMB applicant/recipient on buy-in in another state cannot be approved for QMB in New Mexico until the other state's buy-in is terminated.
[8.240.400.15 NMAC - Rp 8.240.400.15 NMAC, 7/1/2024]

8.240.400.16 SPECIAL RECIPIENT REQUIREMENTS: There is no special recipient requirements such as age or disability for QMB.
[8.240.400.16 NMAC - Rp 8.240.400.16 NMAC, 7/1/2024]

8.240.400.17 RECIPIENT RIGHTS AND RESPONSIBILITIES: An applicant/recipient is responsible for establishing their eligibility for medicaid. As part of this responsibility, the applicant/recipient must provide required information and documents or take the actions necessary to establish eligibility. Failure to do so must result in a decision that eligibility does not exist. An applicant/recipient must also grant the HCA permission to contact other persons, agencies or sources of information which are necessary to establish eligibility.
[8.240.400.17 NMAC - Rp 8.240.400.17 NMAC, 7/1/2024]

8.240.400.18 ASSIGNMENTS OF MEDICAL SUPPORT: Refer to medical assistance program manual Subsection F of 8.200.420.12 NMAC.
[8.240.400.18 NMAC - Rp 8.240.400.18 NMAC, 7/1/2024]

8.240.400.19 REPORTING REQUIREMENTS: All medicaid recipients must report any change in their circumstances which can affect eligibility to the local income support division (ISD) office within 10 days of the change.
[8.240.400.19 NMAC - Rp 8.240.400.19 NMAC, 7/1/2024]

HISTORY OF 8.240.400 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:
MAD Rule 840, Qualified Medicare Beneficiaries, filed 3/7/1989.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 3/31/1989.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 12/29/1989.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 6/22/1990.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 12/4/1990.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 5/3/1991.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 6/30/1992.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 9/26/1994.

History of Repealed Material:
MAD Rule 840, Qualified Medicare Beneficiaries, filed 9/26/1994 - Repealed effective 2/1/1995.
8.240.400 NMAC - Recipient Policies (filed 6/13/2003) Repealed effective 7/1/2024.

Other: 8.240.400 NMAC - Recipient Policies (filed 6/13/2003) Replaced by 8.240.400 NMAC - Recipient Policies, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 240 MEDICAID ELIGIBILITY - QUALIFIED MEDICARE BENEFICIARIES (QMB) (CATEGORY 040)
PART 500 INCOME AND RESOURCE STANDARDS

8.240.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.240.500.1 NMAC -Rp 8.240.500.1 NMAC, 7/1/2024]

8.240.500.2 SCOPE: The rule applies to the general public.
[8.240.500.2 NMAC -Rp 8.240.500.2 NMAC, 7/1/2024]

8.240.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.240.500.3 NMAC -Rp 8.240.500.3 NMAC, 7/1/2024]

8.240.500.4 DURATION: Permanent.
[8.240.500.4 NMAC -Rp 8.240.500.4 NMAC, 7/1/2024]

8.240.500.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of the section.
[8.240.500.5 NMAC -Rp 8.240.500.5 NMAC, 7/1/2024]

8.240.500.6 OBJECTIVE: The objective of this rule is to provide eligibility policy and procedures for the medicaid program.
[8.240.500.6 NMAC -Rp 8.240.500.6 NMAC, 7/1/2024]

8.240.500.7 DEFINITIONS: [**RESERVED**]

8.240.500.8 [**RESERVED**]

8.240.500.9 GENERAL NEED DETERMINATION: Applicants for, or recipients of, the qualified medicare beneficiaries (QMB) program must apply for and take all necessary steps to obtain any income or resources to which they may be entitled. Recipients of supplemental security income (SSI) or aid to families with dependent children (AFDC) who apply for QMB are excluded from this requirement. A victim of crime is not required to accept victim compensation payments

from a state-administered fund established to aid crime victims as a condition of eligibility.
[8.240.500.9 NMAC -Rp 8.240.500.9 NMAC, 7/1/2024]

8.240.500.10 RESOURCE STANDARDS: The value of an applicant/recipient's individual countable resources must not exceed the amount set forth in Section 8.200.510.14 NMAC, resource amounts for supplemental security income (SSI) related medicare savings programs (QMB and SLIMB/QI). The resource limit for an applicant couple is the amount set forth in Section 8.200.510.14 NMAC. An applicant/recipient with an ineligible spouse is eligible if the couple's countable resources do not exceed the amount set forth in Section 8.200.510.14 NMAC, when resources are deemed. The resource determination is always made as of the first moment of the first day of the month. The applicant/recipient is ineligible for any month in which the countable resources exceed the current resource standard as of the first moment of the first day of the month. Changes in the amount of resources during a month do not affect eligibility for that month. See Section 8.215.500.13 NMAC, countable resources, and Section 8.215.500.14 NMAC, resource exclusions, for specific information on exclusions, disregards, and calculation of countable resources.
[8.240.500.10 NMAC -Rp 8.240.500.10 NMAC, 7/1/2024]

8.240.500.11 RESOURCE TRANSFERS: The social security administration excluded transfer of resources as a factor of eligibility for non-institutionalized SSI recipients. Transfer of resources is not a factor for consideration in categories that use SSI methodology in the eligibility determination.
[8.240.500.11 NMAC -Rp 8.240.500.11 NMAC, 7/1/2024]

8.240.500.12 TRUSTS: See Section 8.281.510 NMAC and following subsections.
[8.240.500.12 NMAC -Rp 8.240.500.12 NMAC, 7/1/2024]

8.240.500.13 INCOME STANDARDS: The income ceiling for QMB eligibility is one hundred percent of the federal income poverty guidelines. These guidelines are updated annually effective April 1st. See Section 8.200.520 NMAC, *Income Standards*. If the applicant is a minor child, income must be deemed from the parent(s). Income must be verified and documented in the case record. See Section 8.215.500.13 NMAC, *countable resources*, and Section 8.215.500.14 NMAC, *resource exclusions*, for specific information on exclusions, disregards, and calculation of countable income.
[8.240.500.13 NMAC -Rp 8.240.500.13 NMAC, 7/1/2024]

8.240.500.14 UNEARNED INCOME:

A. Unearned income exclusions: All social security and railroad retirement beneficiaries receive cost of living adjustments (COLAs) in January of each year. The ISD caseworker must disregard the COLA from January through March when (re)determining QMB eligibility. For redeterminations made in January, February and March and for new QMB applications registered in January, February or March, the ISD caseworker uses the December social security and railroad retirement benefit amounts. For QMB applications registered from April through December, total gross income including the new COLA figures are used to determine income and compared to the new April federal poverty levels. This exclusion does not apply to other types of income.

B. Evaluation of applicant/recipient's income: The ISD caseworker determines the amount of income available to the applicant/recipient using only the applicant/recipient's own income. A standard $20 disregard is allowed in accordance with Section 8.215.500.22 NMAC. The federal poverty level standard disregard is only given if the applicant/recipient lives with an ineligible spouse. See Section 8.240.500.15 NMAC for deemed income.
[8.240.500.14 NMAC -Rp 8.240.500.14 NMAC, 7/1/2024]

8.240.500.15 DEEMED INCOME:

A. Minor applicant/recipient living with parent(**s**): If the applicant/recipient is a minor who lives with a parent(s), deemed income from the parent(s) must be considered in accordance with Section 8.215.500.21 NMAC, *deemed income*, and applicable subsections.

B. Applicant/recipient living with an ineligible spouse: If an applicant/recipient is living in the same household with an ineligible spouse, the income of the applicant/recipient and the income of the ineligible spouse must be considered in accordance with the following paragraphs.

(1) Evaluation of applicant/recipient's income: The ISD caseworker determines the amount of income available to the applicant/recipient using only the applicant/recipient's own income. Allow the standard $20 disregard in accordance with instructions in Subsection B of Section 8.215.500.22 NMAC of the medical assistance division policy manual. If the applicant/recipient has earned income, allow the earned income disregard as specified in Subsection C of Section 8.215.500.22 NMAC. From the combined total of the applicant/recipient's remaining earned and unearned income, subtract up to the difference between one hundred percent of the federal income poverty level for two persons and one hundred percent of the federal income poverty level for one person. This is referred to as the FPL disregard. Compare the remaining countable income of the applicant/recipient to the individual income standard for the QMB program. If the applicant/recipient's remaining countable income is greater than the individual standard, they are ineligible for the QMB program. If the applicant/recipient's remaining countable income is less than the

individual income standard, proceed to the following section.

(2) Evaluation of the ineligible spouse's gross income: The ISD caseworker determines the total gross earned and unearned income of the ineligible spouse. From this combined amount, subtract a living allowance for any ineligible minor dependent child(ren) of either member of the couple who live(s) in the home. The deductible amount of the ineligible child(ren)'s living allowance cannot exceed the ineligible spouse's total gross income. The amount of the living allowance for an ineligible child is determined by subtracting the child's gross income from the figure which represents the difference between one hundred percent of the federal income poverty level for two persons and one hundred percent of the federal income poverty level for one person. A "child" must be under 18 years of age or under 21 years of age if a full-time student at an institution of learning.

(3) Determination of countable income for eligibility purposes: The ISD caseworker adds the gross unearned income of the applicant/recipient (without applying any disregards) to the gross unearned income of the ineligible spouse. The ISD caseworker then adds the total gross earned income of the applicant/recipient to the total gross earned income of the ineligible spouse. From the combined total gross earnings of the couple, the ISD caseworker subtracts one earned income disregard (the first $65 of the total earnings plus one half of the remainder). The resulting figure is the total combined countable earnings of the couple. Add the couple's total combined countable earned income to their total gross unearned income. From this figure subtract the standard $20 disregard determined in accordance with Subsection B of Section 8.215.500.22 NMAC. Next, subtract the amount of the FPL disregard which the applicant/recipient was allowed. Finally, subtract the amount of the ineligible child(ren)'s living allowance which was calculated in Paragraph (2) of Subsection B of Section 8.240.500.14 NMAC. The resulting figure is the countable income of the couple. Compare it to the couple standard for QMB. If the countable income of the couple exceeds the couple standard, the applicant/recipient is ineligible for the QMB program. If the countable income of the couple is less than the couple standard, the applicant/recipient is eligible for the QMB program of the factor of income.
[8.240.500.15 NMAC -Rp 8.240.500.15 NMAC, 7/1/2024]

HISTORY OF 8.240.500 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:
MAD Rule 840, Qualified Medicare Beneficiaries, filed 3/7/1989.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 3/31/1989.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 12/29/1989.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 6/22/1990.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 12/4/1990.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 5/3/1991.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 6/30/1992.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 9/26/1994.

History of Repealed Material:
MAD Rule 840, Qualified Medicare Beneficiaries, filed 9/26/1994 - Repealed effective 2/1/1995.
8.240.500 NMAC - Income And Resource Standards (filed 6/25/2010) Repealed effective 7/1/2024.

Other: 8.240.500 NMAC - Income And Resource Standards (filed 6/25/2010) Replaced by 8.240.500 NMAC - Income And Resource Standards, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 240 MEDICAID ELIGIBILITY - QUALIFIED MEDICARE BENEFICIARIES (QMB) (CATEGORY 040)
PART 600 BENEFIT DESCRIPTION

8.240.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.240.600.1 NMAC - Rp, 8.240.600.1 NMAC, 7/1/2024]

8.240.600.2 SCOPE: The rule applies to the general public.
[8.240.600.2 NMAC - Rp, 8.240.600.2 NMAC, 7/1/2024]

8.240.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 191991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.240.600.3 NMAC - Rp, 8.240.600.3 NMAC, 7/1/2024]

8.240.600.4 DURATION: Permanent.
[8.240.600.4 NMAC - Rp, 8.240.600.4 NMAC, 7/1/2024]

8.240.600.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.240.600.5 NMAC - Rp, 8.240.600.5 NMAC, 7/1/2024]

8.240.600.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.240.600.6 NMAC - Rp, 8.240.600.6 NMAC, 7/1/2024]

8.240.600.7 DEFINITIONS: [**RESERVED**]

8.240.600.8 [**RESERVED**]

8.240.600.9 BENEFIT DESCRIPTION: For qualified medicare beneficiaries (QMB), medicaid covers payment of medicare premium amounts for Parts A and B and the coinsurance and deductibles on medicare-covered services. Medicaid does not pay for services which are not medicare benefits, services denied by medicare, or services furnished by providers who have not accepted medicare assignment. Reimbursement is made to providers of covered services and not directly to recipients.
[8.240.600.9 NMAC - Rp, 8.240.600.9 NMAC, 7/1/2024]

8.240.600.10 BENEFIT DETERMINATION: Application for QMB is made on the assistance application form. A separate application is not required if the recipient is receiving medicaid under another category. The income support specialist (ISS) must act on applications and send notice of action taken to the applicant within 45 days after the date of application. After the eligibility determination is made, notice of the approval or denial is sent to the applicant. If the application is denied, this notice includes the reason for the denial and an explanation of the recipient's right to a hearing
[8.240.600.10 NMAC - Rp, 8.240.600.10 NMAC, 7/1/2024]

8.240.600.11 INITIAL BENEFITS: Eligibility begins the month after the month the case is approved. No retroactive coverage is available. Enrollment periods for medicare coverage: Individuals who are not entitled to free medicare Part A can purchase it. This is called "premium" or "conditional" Part A coverage. Applicants who are entitled to free medicare Part A may apply for QMB at any time. Enrollment for premium/conditional medicare Part A, is accepted by the social security administration (SSA) once a year, from January through March, with coverage starting in July. If a QMB applicant has an award letter or medicare card showing premium/ conditional enrollment for July, the case can be approved in June with coverage beginning in July.
[8.240.600.11 NMAC - Rp, 8.240.600.11 NMAC, 7/1/2024]

8.240.600.12 ONGOING BENEFITS: A redetermination of eligibility conditions must be made at least every 12 months but no more frequently than every six months.
[8.240.600.12 NMAC - Rp, 8.240.600.12 NMAC, 7/1/2024]

8.240.600.13 RETROACTIVE BENEFITS: No retroactive medicaid benefits are available for applicants/recipients in this category.
[8.240.600.13 NMAC - Rp, 8.240.600.13 NMAC, 7/1/2024]

8.240.600.14 CHANGES IN ELIGIBILITY: A case is closed when the recipient becomes ineligible, with provision of advance notice. If a recipient dies, the case is closed the following month.
[8.240.600.14 NMAC - Rp, 8.240.600.14 NMAC, 7/1/2024]

HISTORY OF 8.240.600 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
MAD Rule 840, Qualified Medicare Beneficiaries, filed 3/7/1989.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 3/31/1989.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 12/29/1989.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 6/22/1990.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 12/4/1990.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 5/3/1991.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 6/30/1992.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 9/26/1994.

History of Repealed Material:
MAD Rule 840, Qualified Medicare Beneficiaries, filed 9/26/1994 - Repealed effective 2/1/1995.
8.240.600 NMAC - Benefit Description (filed 9/3/2013) Repealed effective 7/1/2024.

Other: 8.240.600 NMAC - Benefit Description (filed 9/3/2013) Replaced by 8.240.600 NMAC - Benefit Description effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 245 MEDICAID ELIGIBILITY - SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLIMB) (CATEGORY 045)
PART 400 RECIPIENT POLICIES

8.245.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.245.400.1 NMAC - Rp 8.245.400.1 NMAC, 7/1/2024]

8.245.400.2 SCOPE: The rule applies to the general public.
[8.245.400.2 NMAC - Rp 8.245.400.2 NMAC, 7/1/2024]

8.245.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.245.400.3 NMAC - Rp 8.245.400.3 NMAC, 7/1/2024]

8.245.400.4 DURATION: Permanent.
[8.245.400.4 NMAC - Rp 8.245.400.4 NMAC, 7/1/2024]

8.245.400.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.245.400.5 NMAC - Rp 8.245.400.5 NMAC, 7/1/2024]

8.245.400.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.245.400.6 NMAC - Rp 8.245.400.6 NMAC, 7/1/2024]

8.245.400.7 DEFINITIONS: [**RESERVED**]

8.245.400.8 MISSION: To 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.
[8.245.400.8 NMAC - Rp 8.245.400.8 NMAC, 7/1/2024]

8.245.400.9 SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLIMB) - CATEGORY 045: To be eligible for category 045, an applicant/recipient must be covered by medicare part A. The part A insurance is a free entitlement to social security beneficiaries who are 65 years of age or older or who have received social security disability payments for 24 months. Fully or currently insured workers, or their dependents, with end-stage renal disease are also covered under medicare.
[8.245.400.9 NMAC - Rp 8.245.400.9 NMAC, 7/1/2024]

8.245.400.10 BASIS FOR DEFINING THE GROUP: Specified low income medicare beneficiaries (SLIMB) are individuals who would be qualified medicare beneficiaries (QMBs) but for the fact that their income exceeds the income levels established for QMB. Income eligibility for the SLIMB is at least one hundred percent of the federal income poverty level, but less than one hundred twenty percent.
[8.245.400.10 NMAC - Rp 8.245.400.10 NMAC, 7/1/2024]

8.245.400.11 [RESERVED]

8.245.400.12 ENUMERATION: SLIMB applicants/recipients must furnish their social security account number(s). SLIMB eligibility must be denied or terminated for applicants/recipients who fail to furnish social security numbers.
[8.245.400.12 NMAC - Rp 8.245.400.12 NMAC, 7/1/2024]

8.245.400.13 CITIZENSHIP AND IDENTITY: Individuals entitled to or receiving medicare already meet citizenship and identity requirements.
[8.245.400.13 NMAC - Rp 8.245.400.13 NMAC, 7/1/2024]

8.245.400.14 RESIDENCE: To be eligible for SLIMB, an applicant/recipient must be physically present in New Mexico on the date of application or final determination of eligibility and must have demonstrated intent to remain in the state. A temporary absence from the state does not prevent eligibility. A temporary absence exists when an applicant/recipient leaves the state for a specific purpose with a time-limited goal and intends to return to New Mexico when the purpose is accomplished.
[8.245.400.14 NMAC - Rp 8.245.400.14 NMAC, 7/1/2024]

8.245.400.15 NONCONCURRENT RECEIPT OF ASSISTANCE: SLIMB applicants on buy-in in another state cannot be approved for the New Mexico SLIMB program until buy-in from the other state is terminated.
[8.245.400.15 NMAC - Rp 8.245.400.15 NMAC, 7/1/2024]

8.245.400.16 SPECIAL RECIPIENT REQUIREMENTS: Applicants/recipients for SLIMB eligibility must meet the specified age or disability requirements to be eligible for medicare part A. There is no age requirement for SLIMB eligibility.
[8.245.400.16 NMAC - Rp 8.245.400.16 NMAC, 7/1/2024]

8.245.400.17 RECIPIENT RIGHTS AND RESPONSIBILITIES: An applicant/recipient is responsible for establishing his/her eligibility for medicaid. As part of this responsibility, the applicant/recipient must provide required information and documents or take the actions necessary to establish eligibility. Failure to do so must result in a decision that eligibility does not exist. An applicant/recipient must also grant the HCA permission to contact other persons, agencies or sources of information which are necessary to establish eligibility.
[8.245.400.17 NMAC - Rp 8.245.400.17 NMAC, 7/1/2024]

8.245.400.18 ASSIGNMENT OF SUPPORT: Assignment of medical support: As a condition of eligibility, applicants for or recipients of benefits must do the following, 42 CFR Section 433.146; Subsection G of Section 27-2-28 NMSA 1978 (Repl. Pamp. 1991):

A. assign individual rights to medical support and payments to the HCA the assignment authorizes HCA to pursue and make recoveries from liable third parties on behalf of a recipient;

B. assign the rights to medical support and payments of other individuals eligible for medicaid, for whom they can legally make an assignment; and

C. assign their individual rights to any medical care support available under an order of a court or an administrative agency.
[8.245.400.18 NMAC - Rp 8.245.400.18 NMAC, 7/1/2024]

8.245.400.19 REPORTING REQUIREMENTS: Medicaid recipients must report any change in

their circumstances which may affect eligibility within 10 days after the change to the local income support division (ISD) office.
[8.245.400.19 NMAC - Rp 8.245.400.19 NMAC, 7/1/2024]

HISTORY OF 8.245.400 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
MAD Rule 843, Specified Low Income Medicare Beneficiaries, filed 9/26/1994.

History of Repealed Material:
MAD Rule 843, Specified Low Income Medicare Beneficiaries, filed 9/26/1994 - Repealed effective 2/1/1995.
8.245.400 NMAC - Recipient Policies (filed 11/16/2009) Repealed effective 7/1/2024.

Other: 8.245.400 NMAC - Recipient Policies (filed 11/16/2009) Replaced by 8.245.400 NMAC - Recipient Policies effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 245 MEDICAID ELIGIBILITY - SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLIMB) (CATEGORY 045)
PART 500 INCOME AND RESOURCE STANDARDS

8.245.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.245.500.1 NMAC - Rp 8.245.500.1 NMAC, 7/1/2024]

8.245.500.2 SCOPE: The rule applies to the general public.
[8.245.500.2 NMAC - Rp 8.245.500.2 NMAC, 7/1/2024]

8.245.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.245.500.3 NMAC - Rp 8.245.500.3 NMAC, 7/1/2024]

8.245.500.4 DURATION: Permanent.
[8.245.500.4 NMAC - Rp 8.245.500.4 NMAC, 7/1/2024]

8.245.500.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.245.500.5 NMAC - Rp 8.245.500.5 NMAC, 7/1/2024]

8.245.500.6 OBJECTIVE: The objective of this rule is to provide eligibility policy and procedures for the medicaid program.
[8.245.500.6 NMAC - Rp 8.245.500.6 NMAC, 7/1/2024]

8.245.500.7 DEFINITIONS: [**RESERVED**]

8.245.500.8 MISSION: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.245.500.8 NMAC - Rp 8.245.500.8 NMAC, 7/1/2024]

8.245.500.9 NEED DETERMINATION: SLIMB applicants/recipients must apply for and take all necessary steps to obtain any resources to which they may be entitled.
[8.245.500.9 NMAC - Rp 8.245.500.9 NMAC, 7/1/2024]

8.245.500.10 RESOURCE STANDARDS: The value of an applicant/recipient's countable resources must not exceed the amount set forth in 8.200.510.14 NMAC, *resource amounts for supplemental security income (SSI) related medicare savings programs (QMB and SLIMB/QI1).* The resource limit for an applicant couple cannot exceed the amount for a couple set forth in 8.200.510.14 NMAC. An applicant/recipient with an ineligible spouse is eligible if the couple's countable resources do not exceed the amount set forth in 8.200.510.14 NMAC, when resources are deemed. A resource determination is always made as of the first moment of the first day of the month. An applicant/recipient is ineligible for any month in which the countable resources exceed the current resource standard as of the first moment of the first day of the month. Changes in the amount of resources during a month do not affect eligibility for that month. See 8.215.500.13 NMAC, *countable resources,* and 8.215.500.14 NMAC, *resource exclusions*, for information on exclusions, disregards, and countable resources.
[8.245.500.10 NMAC - Rp 8.245.500.10 NMAC, 7/1/2024]

8.245.500.11 RESOURCE TRANSFERS: The social security administration excluded transfer of resources as a factor of eligible for non-institutionalized SSI recipients. Transfer of resources is not a factor for consideration in the medicare savings programs.
[8.245.500.11 NMAC - Rp 8.245.500.11 NMAC, 7/1/2024]

8.245.500.12 TRUSTS: See 8.281.510 NMAC and following subsections.
[8.245.500.12 NMAC - Rp 8.245.500.12 NMAC, 7/1/2024]

8.245.500.13 INCOME STANDARDS: Income standards for this category are at least one hundred percent but no more than one hundred twenty percent of the federal income poverty guidelines. The federal income poverty guidelines are adjusted annually, effective April 1. See 8.200.520 NMAC, *Income*

Standards, and 8.215.500.19 NMAC, *Income Standards*, for information on exclusions, disregards, and countable income. Verification of income must be documented in the case file.
[8.245.500.13 NMAC - Rp 8.245.500.13 NMAC, 7/1/2024]

8.245.500.14 UNEARNED INCOME: Unearned income exclusions: All social security and railroad retirement beneficiaries receive cost of living adjustments (COLAs) in January of each year. The ISD caseworker must disregard the COLA from January through March when (re)determining SLIMB eligibility. For redeterminations made in January, February and March and for new SLIMB applications registered in January, February, or March, the ISD caseworker uses the December social security and railroad retirement benefit amounts. For SLIMB applications registered from April through December, total gross income including the new COLA figures are used to determine income and compared to the new April federal poverty levels. This exclusion does not apply to other types of income.
[8.245.500.14 NMAC - Rp 8.245.500.14 NMAC, 7/1/2024]

8.245.500.15 DEEMED INCOME: If an applicant/recipient is a minor who lives with a parent(s), deemed income from the parent(s) must be considered. If an applicant/recipient is married and lives with a spouse, deemed income from the spouse must be considered. See 8.215.500.21 NMAC, *Deemed Income,* for information on deemed income.
[8.245.500.15 NMAC - Rp 8.245.500.15 NMAC, 7/1/2024]

HISTORY OF 8.245.500 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
MAD Rule 843, Specified Low Income Medicare Beneficiaries, filed 9/26/94.

History of Repealed Material:
MAD Rule 843, Specified Low Income Medicare Beneficiaries, filed 9/26/1994 - Repealed effective 2/1/1995.
8.245.500 NMAC - Income And Resource Standards (filed 11/16/2009) Repealed effective 7/1/2024.

Other: 8.245.500 NMAC - Income And Resource Standards (filed 11/16/2009) Replaced by 8.245.500 NMAC - Income And Resource Standards effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 248 MEDICAID ELIGIBILITY - MEDICARE DRUG COVERAGE (CATEGORY 048)
PART 400 RECIPIENT POLICIES

8.248.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.248.400.1 NMAC - Rp, 8.248.400.1 NMAC, 7/1/2024]

8.248.400.2 SCOPE: The rule applies to the general public.
[8.248.400.2 NMAC - Rp, 8.248.400.2 NMAC, 7/1/2024]

8.248.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). The legal basis for the low-income subsidy (LIS) program is the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Public Law 108-173. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.248.400.3 NMAC - Rp, 8.248.400.3 NMAC, 7/1/2024]

8.248.400.4 DURATION: Permanent.
[8.248.400.4 NMAC - Rp, 8.248.400.4 NMAC, 7/1/2024]

8.248.400.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.248.400.5 NMAC - Rp, 8.248.400.5 NMAC, 7/1/2024]

8.248.400.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicare part D - low-income subsidy program.
[8.248.400.6 NMAC - Rp, 8.248.400.6 NMAC, 7/1/2024]

8.248.400.7 DEFINITIONS: [**RESERVED**]

8.248.400.8 [**RESERVED**]

8.248.400.9 LOW-INCOME SUBSIDY FOR MEDICARE PART D ELIGIBLES: Applicants/recipients who meet certain income and other non-financial requirements can be eligible for the low-income subsidy (LIS) under medicare part D.
[8.248.400.9 NMAC - Rp, 8.248.400.9 NMAC, 7/1/2024]

8.248.400.10 BASIS FOR DEFINING THE GROUP:

A. Medicare recipients who are eligible for part D medicare coverage under the MMA of 2003 may be eligible for the low-income subsidy program. Eligibility is based on financial criteria, both income and resources, of applicant and spouse (if any) for the appropriate family size.

B. Family size: The following persons are included in the family size:

(1) the applicant;

(2) the applicant's spouse, if living with the applicant; and

(3) any persons who are related by blood, marriage, or adoption, who are living with the applicant and spouse and who are dependent on the applicant or spouse for at least one half of their financial support.
[8.248.400.10 NMAC - Rp, 8.248.400.10 NMAC, 7/1/2024]

8.248.400.11 GENERAL RECIPIENT REQUIREMENTS:

A. Medicare: Applicants must be eligible for and receiving part A or part B medicare benefits.

B. Residence: To be eligible for the low-income subsidy, an applicant/recipient must be physically present in New Mexico on the date of application or final determination of eligibility and must have demonstrated intent to remain in the state. Eligibility for the low-income subsidy (LIS) will transfer to New Mexico if determined by the social security administration (SSA) in another state. If eligibility was determined by another state (not SSA), eligibility must be re-determined in New Mexico.
[8.248.400.11 NMAC - Rp, 8.248.400.11 NMAC, 7/1/2024]

8.248.400.12 SPECIAL RECIPIENT REQUIREMENTS: Applicants/recipients must be enrolled in a part D prescription drug plan (PDP) or a medicare advantage prescription drug (MA-PD) plan.
[8.248.400.12 NMAC - Rp, 8.248.400.12 NMAC, 7/1/2024]

8.248.400.13 RECIPIENT RIGHTS AND RESPONSIBILITIES: An applicant/recipient is responsible for establishing their eligibility for the LIS.

A. As part of this responsibility, the applicant/recipient must provide required information and documents or take the actions necessary to establish eligibility. Failure to do so must result in a decision that eligibility does not exist.

B. An applicant/recipient must also grant the HCA permission to contact other persons, agencies or sources of information that are necessary to establish eligibility.

C. An applicant can voluntarily withdraw an application any time prior to the determination of eligibility. The ISD office advises an applicant that withdrawing an application has no effect upon their right to apply for assistance in the future.
[8.248.400.13 NMAC - Rp, 8.248.400.13 NMAC, 7/1/2024]

8.248.400.14 REPORTING REQUIREMENTS: A LIS recipient must report to the local ISD office any change in their circumstances that might affect eligibility within 10 days of the change.
[8.248.400.14 NMAC - Rp, 07/01/2024]

HISTORY OF 8.248.400 NMAC:
8.248.400 NMAC - Recipient Policies (filed 1/13/2006) Repealed effective 7/1/2024.

Other: 8.248.400 NMAC - Recipient Policies (filed 1/13/2006) Replaced by 8.248.400 NMAC - Recipient Policies effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 248 MEDICAID ELIGIBILITY - MEDICARE DRUG COVERAGE (CATEGORY 048)
PART 500 INCOME AND RESOURCE STANDARDS

8.248.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.248.500.1 NMAC - Rp 8.248.500.1 NMAC, 7/1/2024]

8.248.500.2 SCOPE: The rule applies to the general public.
[8.248.500.2 NMAC - Rp 8.248.500.2 NMAC, 7/1/2024]

8.248.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). The legal basis for the low-income subsidy (LIS) program is the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Public Law 108-173. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.248.500.3 NMAC - Rp 07/01/2024]

8.248.500.4 DURATION: Permanent.
[8.248.500.4 NMAC - Rp 8.248.500.4 NMAC, 7/1/2024]

8.248.500.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.248.500.5 NMAC - Rp 8.248.500.5 NMAC, 7/1/2024]

8.248.500.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicare part D (drug benefit) - low income subsidy program.
[8.248.500.6 NMAC - Rp 8.248.500.6 NMAC, 7/1/2024]

8.248.500.7 DEFINITIONS: [**RESERVED**]

8.248.500.8 [**RESERVED**]

8.248.500.9 NEED DETERMINATION: This section describes the methodology to be used in determining countable resources and income for the low-income subsidy (LIS) program which is based in part on supplemental security income (SSI) methodology. These

guidelines are used for initial and on-going eligibility for medicare beneficiaries enrolled in part A or part B medicare. LIS eligibility is determined prospectively. Applicants/recipients must meet, or expect to meet, all financial and non-financial eligibility criteria in the month for which a determination of eligibility is made.
[8.248.500.9 NMAC - Rp 8.248.500.9 NMAC, 7/1/2024]

8.248.500.10 APPLICATION PROCESS: The income support division (ISD) office is responsible for taking LIS applications from those individuals who do not want to submit their application to the social security administration either directly or through the ISD office.

A. Who does not have to apply: Certain groups of medicare beneficiaries who are also receiving medicaid do not have to apply for the LIS. These individuals are called "deemed eligible" and will automatically be put on the LIS:

(1) full-benefit dual eligibles, who are persons eligible for both medicare and have full medicaid benefits (including drug benefits);

(2) SSI recipients;

(3) medicare beneficiaries, who are participants in the medicare saving programs, which are: QMB, SLIMB, and QI-1;

(4) working disabled individuals (WDI) who are receiving medicare;

(5) HCBW recipients who are receiving medicare; and

(6) individuals screened for QMB, SLIMB, or QI-1 and determined eligible before the application for LIS is processed.

B. Who can apply: medicare beneficiaries who are not deemed eligible (See Paragraphs (1) through (6) above) and who insist on filing their application with the state rather than with social security administration (SSA).
[8.248.500.10 NMAC - Rp 8.248.500.10 NMAC, 7/1/2024]

8.248.500.11 RESOURCE STANDARDS: A "resource" is defined as cash and other assets that can be converted to cash within 20 days.

A. Resource determination: The resource determination is made as of the first moment of the first day of the month. An applicant/recipient is ineligible for any month in which their countable resources exceed the allowable resource standard as of the first moment of the first day of the month. Changes in the amount of countable resources during a month do not affect eligibility or ineligibility for that month.

B. Distinguishing between resources and income: Resources must be distinguished from income to avoid counting a single asset twice. As a general rule, ownership of a resource precedes the current month while income is received in the current month. Income held by an applicant/recipient until the following month becomes a resource.
[8.248.500.11 NMAC - Rp 8.248.500.11 NMAC, 7/1/2024]

8.248.500.12 APPLICABLE RESOURCE STANDARDS: The resource standard for the LIS is $10,000 for an individual and $20,000 for a couple. Resources belonging to other dependent family members are not considered.

A. Cash resources: The face value of cash, savings or checking accounts is considered in determining LIS eligibility.

(1) An applicant/recipient must provide verification of the value of all cash resources. The resource value of a bank account is customarily verified by a statement from the bank showing the account balance as of the first moment of the first day of the month in question. If an applicant/recipient cannot provide this verification, the ISD worker sends a bank or postal savings clearance to the appropriate institution(s).

(2) If the applicant/recipient can demonstrate that a check was written and delivered to a payee but not cashed by the payee prior to the first moment of the first day of the month, the amount of that check is subtracted from the applicant/recipient's checking account balance to arrive at the amount to be considered a countable resource.

B. Other resources: The value of other resources is evaluated according to the applicant/spouse's equity in the resource(s). The equity value of an item is defined as the price for which that item, minus any encumbrances, can reasonably be expected to sell on the open market in the particular geographic area. Other resources which can be converted to cash within 20 days include, but are not limited to: stocks, bonds, mutual fund shares, promissory notes, mortgages, whole life insurance policies, financial institution accounts (savings, checking, CDs, IRAs, 401(K) accounts, and annuities), and real property not contiguous with home property.
[8.248.500.12 NMAC - Rp 8.248.500.12 NMAC, 7/1/2024]

8.248.500.13 COUNTABLE RESOURCES: Before a resource can be considered countable, the three criteria listed below must be met.

A. Ownership interest: An applicant/recipient must have an ownership interest in a resource for it to be countable. The fact that an applicant/recipient has access to a resource, or has a legal right to use it, does not make it countable unless the applicant/recipient also has an ownership interest in it.

B. Legal right to convert resource to cash: An applicant/recipient must have the legal ability to spend the funds or to convert non-cash resources into cash.

(1) Physical possession of resource: The fact that an applicant/recipient does not have physical possession of a resource does not mean it is not their resource. If they have the legal ability to spend the funds or convert the resource to cash, the resource is considered countable. Physical possession of savings bonds

is a legal requirement for cashing them.

(2) Unrestricted use of resource: An applicant/recipient is considered to have free access to the unrestricted use of a resource even if he can take those actions only through an agent, such as a representative payee or guardian.

(3) If there is a legal bar to the sale of a resource, such as a co-owner legally blocking the sale of jointly owned property, the resource is not countable. The applicant/recipient is not required to undertake litigation in order to accomplish the sale.

C. Legal ability to use a resource: If a legal restriction exists which prevents the use of a resource for the applicant/recipient's own support and maintenance, the resource is not countable.

D. Jointly-held account: If the applicant/spouse is the only subsidy claimant or subsidy recipient who is an account holder on a jointly held account, the state will presume that all of the funds in the account belong to the applicant/spouse. If more than one subsidy claimant or subsidy recipient are account holders, the state will presume that the funds in the account belong to those individuals in equal shares. If the applicant/spouse disagrees with the ownership presumption described in this subsection, they may rebut the presumption. Rebuttal is a procedure that permits an individual to furnish evidence and establish that some or all of the funds in the jointly-held account do not belong to them.
[8.248.500.13 NMAC - Rp 8.248.500.13 NMAC, 7/1/2024]

8.248.500.14 RESOURCE EXCLUSIONS: The following resources are not to be considered for purposes of determining LIS eligibility:

A. Applicant's home: A home is any property in which the applicant and spouse have an ownership interest and which serves as the applicant's principal place of residence. There is no restriction on acreage of home property. This property includes the shelter in which an individual resides, the land on which the shelter is located, and any outbuildings.

B. Non-liquid resources, other than real property: These include, but are not limited to:

(1) household goods and personal effects;

(2) automobiles, trucks, tractors and other vehicles;

(3) machinery and livestock; and

(4) non-cash business property.

C. Property of a trade or business: Property of a trade or business that is essential to the applicant/spouse's means of self-support.

D. Non-business property: Non-business property that is essential to the applicant/spouse's means of self-support.

E. Stock in regional or village corporations: Stock in regional or village corporations held by natives of Alaska during the 20-year period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act.

F. Whole life insurance: Whole life insurance owned by an individual (and spouse, if any) if the total face value of all the life insurance policies on any person does not exceed $1,500. When the total face value of all policies exceeds $1,500, the cash surrender value of all policies is countable.

G. Term life insurance: Term life insurance that has no cash surrender value.

H. Restricted, allotted Indian lands: Restricted, allotted Indian lands, if the Indian/owner cannot dispose of the land without the permission of other individuals, their tribe, or an agency of the federal government.

I. Payments or benefits: Payments or benefits provided under a federal statute other than title XVI of the act where exclusion is required by such statute.

J. Federal disaster relief: Federal disaster relief assistance received on account of a presidentially declared major disaster, including accumulated interest, or comparable state or local assistance.

K. Funds of $1,500: Funds of $1,500 for the individual and $1,500 for the spouse who lives with the individual if these funds are intended to be used for funeral or burial expenses of the individual and spouse.

L. Burial spaces: Burial spaces, including burial plots, gravesites, crypts, mausoleums, urns, niches, vaults, headstones, markers, plaques, burial containers, opening and closing of the gravesite, and other customary and tradition repositories for the deceased's bodily remains, for the applicant/spouse.

M. Retained retroactive SSI or social security: Retained retroactive SSI or social security benefits for nine months after the month they are received.

N. Certain housing assistance:

O. Refunds: Refunds of federal income taxes and advances made by an employer relating to an earned income tax credit for the month following the month of receipt, and refunds of child tax credits for nine months after the month they are received.

P. Payments: Payments received as compensation incurred or losses suffered as a result of a crime (victims' compensation payments), for nine months beginning with the month following the month of receipt.

Q. Relocation assistance: Relocation assistance for a state or local government, for nine months, beginning with the month following the month of receipt.

R. Dedicated financial institution accounts: Dedicated financial institution accounts consisting of past-due benefits for an SSI-eligible individual under age 18.

S. Gifts: A gift to, or for the benefit of, an individual who has not attained 18 years of age and who has a life-threatening

condition, from an organization described in section 501(c)(3) of the internal revenue code of 1986 which is exempt from taxation under Section 501(a) of such code. The resource exclusion applies to any in-kind gift that is not converted to cash, or to a cash gift that does not exceed $2,000.

T. Funds received: Funds received from a government or nongovernmental agency, program, or health insurance policy whose purpose is to provide medical care or medical services or social services and conserved to pay for medical or social services.

[8.248.500.14 NMAC - Rp 8.248.500.14 NMAC, 7/1/2024]

8.248.500.15 INCOME STANDARDS: Income is anything the applicant/spouse receives in cash or in-kind that can be used to meet their needs for food or shelter. The gross income of the applicant, and their spouse if living together, but not dependent family members, will be considered. However, dependent family members will be counted in the family size.

[8.248.500.15 NMAC - Rp 8.248.500.15 NMAC, 7/1/2024]

8.248.500.16 EARNED INCOME:

A. Earned income: Earned income consists of the following types of payments:

(1) wages counted at the earliest of: when received, when credited to the person employed, or when set aside for the employee's use;

(2) net earnings from self-employment counted on a taxable year basis; net losses, if any, are deducted from other earned income, but not from unearned income;

(3) payments for services performed in a sheltered workshop or work activities center counted when received or set aside for the employee's use;

(4) royalties earned by an individual in connection with any publication of their work and any honoraria received for services rendered; and

(5) in-kind earned income is counted based on current market value. If the applicant/spouse receives an item that is not fully paid for and they are responsible for the balance, only the paid up value is income to the applicant.

B. Period under consideration: The period for which earned income is counted is, in 2006, the remainder of the calendar year, starting with the month of application for the subsidy. Adjust prospective earned income based on the number of months remaining in the calendar year. The income standard against which the income is measured should be adjusted to reflect the same number of months. For subsidy applications filed in 2005, eligibility cannot begin prior to January 1, 2006.

C. Earned income exclusions: Earned income exclusions apply in the order listed below:

(1) refund of federal income taxes and payments under the earned income tax credit;

(2) the first $30 of earned income per calendar quarter that is received too irregularly or infrequently to be counted as income;

(3) any portion of the $20 per month exclusion that has not been excluded from combined unearned income;

(4) $65 per month of the applicant/spouse's earned income;

(5) for applicants who are under age 65 and receive a social security disability insurance benefit based on disability, sixteen and three-tenths percent of gross earnings for impairment related work expenses (IRWE);

(6) one half of the applicant/spouse's remaining earned income; and

(7) for applicants who are under age 65 and receive a social security disability insurance benefit that is based on blindness, twenty-five percent of gross earnings for blind work expenses (BWE).

[8.248.500.16 NMAC - Rp 8.248.500.16 NMAC, 7/1/2024]

8.248.500.17 UNEARNED INCOME: Unearned income is all income that is not earned income. Unearned income is counted at the earliest of the following points: when received, when credited to the recipient, or when set aside for the recipient's use.

A. Unearned income includes, but is not limited to:

(1) social security;

(2) railroad retirement;

(3) veterans benefits;

(4) temporary assistance for needy families (TANF);

(5) pensions;

(6) annuities;

(7) alimony and support payments;

(8) rents;

(9) workmen's compensation;

(10) in-kind support and maintenance;

(11) death benefits;

(12) royalties not counted as earned income; and

(13) dividends and interest not otherwise excluded under SSI rules.

B. Unearned income disregards:

(1) In-kind support and maintenance is any food and shelter that is given to the applicant/spouse or received because someone else pays for it. This includes room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewage, and garbage collection services. The maximum amount of income countable for in-kind support and maintenance is limited to one third of the monthly SSI benefit rate for an individual or a couple, if the applicant's spouse is counted, or the current market value of the support, whichever is lower.

(2) When

benefits are reduced for overpayments or garnishments, count the gross benefit before deductions.

(3) If part of a payment reflects expenses the applicant/spouse incurred in getting the payment, such as legal fees, damages, or medical expenses, incurred because of an accident, reduce the payment by the amount of the expenses. Do not reduce the payment by the amount of personal income taxes owed on the payment.

(4) Subtract from veterans benefits any amount included in the payment for a dependent. If the applicant/spouse is the dependent, count the portion of the benefit attributable to the dependent if they reside with the veteran or receive their own separate payment from the department of veteran affairs.

(5) Subtract from death benefits the expenses of the deceased person's last illness and death paid by the recipient.

C. Unearned income exclusions: The following types of unearned income are not considered for purposes of determining LIS eligibility:

(1) SSI benefits;

(2) any public agency's refund of taxes on real property or food;

(3) need-based assistance wholly funded by a state or one of its subdivisions, including state supplementation of SSI benefits but not a federal/state grant program such as TANF;

(4) any portion of a grant, scholarship, fellowship, or gift used for paying tuition, fees, or other educational expenses; any portion set aside or used for food, clothing or shelter is countable;

(5) food which the applicant or their spouse raise if it is consumed by them or their household;

(6) assistance received under the Disaster Relief and Emergency Assistance Act and assistance provided under any federal statute because of a catastrophe which the president of the United States declares to be a major disaster;

(7) Alaska longevity bonus payments made to an individual who is a resident of Alaska and who, prior to October 1, 1985, met the 25-year residency requirement for receipt of such payments in effect prior to January 1, 1983, and was eligible for SSI;

(8) payments for providing foster care to a child who was placed in the applicant's home by a public or private nonprofit child placement or child care agency;

(9) any interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement which are left to accumulate and become part of the separate burial fund;

(10) home energy assistance (any assistance related to meeting the costs of heating or cooling a home);

(11) one-third of support payments made to or for the applicant by an absent parent if the applicant is a child;

(12) the first $20 of any unearned income in a month other than income in the form of in-kind support and maintenance received in the household of another and income based on need;

(13) housing assistance-any assistance paid with respect to a dwelling unit under:

(a) the United States Housing Act of 1937;

(b) the National Housing Act;

(c) Section 101 of the Housing and Urban Development Act of 1965;

(d) Title V of the Housing Act of 1949; or

(e) Section 202(h) of the Housing Act of 1959;

(14) any interest accrued on and left to accumulate as part of the value of an excluded burial space purchase agreement;

(15) gift of a domestic travel ticket received by the applicant or their spouse and not converted to cash;

(16) payments made to the applicant or their spouse from a fund established by the state to aid victims of crime;

(17) relocation assistance provided to the applicant or their spouse by the state or local government that is comparable to relocation assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(18) hostile fire pay received from one of the uniformed services;

(19) the first $60 of unearned income received per calendar quarter that is received too irregularly or infrequently to be counted as income; or

(20) any dividends or interest earned on countable resources, any dividends or interest earned on resources excluded under a federal statute other than the Social Security Act, and any dividends or interest excluded under the Social Security Protection Act of 2004.

[8.248.500.17 NMAC - Rp 8.248.500.17 NMAC, 7/1/2024]

8.248.500.18 DEEMED INCOME: Deeming income from a spouse to their minor child(ren) or from one spouse to the other spouse when living in the same household, does not apply.

[8.248.500.18 NMAC - Rp 8.248.500.18 NMAC, 7/1/2024]

8.248.500.19 TOTAL COUNTABLE INCOME: Countable income is the sum of unearned income or earned income for the individual or spouse less disregards or exclusions. Only one earned income exclusion ($65 plus one half of the remainder) is applied and one $20 disregard is applied if using income from both spouses.

[8.248.500.19 NMAC - Rp 8.248.500.19 NMAC, 7/1/2024]

HISTORY OF 8.248.500 NMAC:

[**RESERVED**]

History of Repealed Material: 8.248.500 NMAC - Income And Resource Standards (filed 1/13/2006) Repealed effective 7/1/2024.

Other: 8.248.500 NMAC - Income And Resource Standards (filed 1/13/2006) Replaced by 8.248.500 NMAC - Income And Resource Standards effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 248 MEDICAID ELIGIBILITY - MEDICARE DRUG COVERAGE (CATEGORY 048)
PART 600 BENEFIT DESCRIPTION

8.248.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.248.600.1 NMAC - Rp 8.248.600.1 NMAC, 7/1/2024]

8.248.600.2 SCOPE: The rule applies to the general public.
[8.248.600.2 NMAC - Rp 8.248.600.2NMAC, 7/1/2024]

8.248.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See 27-2-12 et. seq.NMSA 1978 (Repl. Pamp. 1991). The legal basis for the low-income subsidy (LIS) program is the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Public Law 108-173. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.248.600.3 NMAC - Rp 8.248.600.3NMAC, 7/1/2024]

8.248.600.4 DURATION: Permanent.
[8.248.600.4 NMAC - Rp 8.248.600.4NMAC, 7/1/2024]

8.248.600.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.248.600.5 NMAC - Rp 8.248.600.5NMAC, 7/1/2024]

8.248.600.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicare part D - low income subsidy program.
[8.248.600.6 NMAC - Rp 8.248.600.6NMAC, 7/1/2024]

8.248.600.7 DEFINITIONS: [**RESERVED**]

8.248.600.8 [**RESERVED**]

8.248.600.9 GENERAL BENEFIT DESCRIPTION: An individual or couple who is determined eligible for the low income subsidy (LIS) under part D of medicare, is eligible for financial assistance with the monthly premium, the yearly deductible, the per-prescription co-payment, and continuous coverage with no gap prior to reaching $3,600 in out-of-pocket spending. The financial assistance may be full or partial depending on the income, family size and resources of the beneficiary.
[8.248.600.9 NMAC - Rp 8.248.600.9NMAC, 7/1/2024]

8.248.600.10 BENEFIT DETERMINATION: Completed applications must be acted upon and notice of approval, denial, or delay sent out within 45 days of the date of application. The applicant will have time limits explained and be informed of the date by which the application should be processed.
[8.248.600.10 NMAC - Rp 8.248.600.10NMAC, 7/1/2024]

8.248.600.11 INITIAL BENEFITS: Eligibility is always prospective and begins the month of application, but not earlier than January 1, 2006. When an eligibility determination is made, notice of the approval or denial is sent to the individual. If the application is denied, the notice shall include reason for denial and the applicant's right to request a fair hearing.
[8.248.600.11 NMAC - Rp 8.248.600.11NMAC, 7/1/2024]

8.248.600.12 ONGOING BENEFITS: The applicant/recipient is responsible to report changes affecting eligibility within 10 days of when the change took place. A re-determination of eligibility is made every 12 months. If a LIS recipient/applicant becomes eligible for certain medicaid categories; SSI, QMB, SLIMB, QI-1, WDI, IC, and HCBW, they will still be eligible for LIS. CMS will notify the beneficiary that they are now deemed eligible, because of categorical relatedness and will take over the re-determination of eligibility on a yearly basis. A change notice will be sent to the LIS recipient. For the year 2006, all certification periods will end December 31, 2006. Effective January 1, 2007, the certification period will be 12 months from the month of application or re-certification.
[8.248.600.12 NMAC - Rp 8.248.600.12NMAC, 7/1/2024]

8.248.600.13 RETROACTIVE BENEFIT COVERAGE: There is no three month retroactive LIS coverage under this program. The subsidy is effective the beginning of the month of application or January 1, 2006, whichever is later.
[8.248.600.13 NMAC - Rp 8.248.600.13NMAC, 7/1/2024]

HISTORY OF 8.248.600 NMAC: [**RESERVED**]

History of Repealed Material: 8.248.600 NMAC - Benefit Description (filed 1/13/2006) Repealed effective 7/1/2024.

Other: 8.248.600 NMAC - Benefit Description (filed 1/13/2006) Replaced by 8.248.600 NMAC

- Benefit Description effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 252 MEDICAID ELIGIBILITY - BREAST AND CERVICAL CANCER PROGRAM (CATEGORY 052)
PART 400 RECIPIENT POLICIES

8.252.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.252.400.1 NMAC - Rp 8.252.400.1 NMAC, 7/1/2024]

8.252.400.2 SCOPE: The rule applies to the general public.
[8.252.400.2 NMAC - Rp 8.252.400.2 NMAC, 7/1/2024

8.252.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See 27-2-12 et. seq. 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.252.400.3 NMAC - Rp 8.252.400.3 NMAC, 7/1/2024

8.252.400.4 DURATION: Permanent.
[8.252.400.4 NMAC - Rp 8.252.400.4 NMAC, 7/1/2024

8.252.400.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.252.400.5 NMAC - Rp 8.252.400.5 NMAC, 7/1/2024

8.252.400.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.252.400.6 NMAC - Rp 8.252.400.6 NMAC, 7/1/2024

8.252.400.7 DEFINITIONS: [**RESERVED**]

8.252.400.8 MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.252.400.8 NMAC - Rp 8.252.400.8 NMAC, 7/1/2024

8.252.400.9 BREAST AND CERVICAL CANCER (BCC) - Category 052: The HCA is the single state agency designated to administer the medicaid program in New Mexico. The department of health (DOH) and the HCA are charged with developing and implementing a program for uninsured women under the age of 65 years, who have met screening criteria as set forth in the centers for disease control and prevention's (CDC) national breast and cervical cancer early detection program (NBCCEDP). The DOH is responsible for verifying that women referred for treatment have met screening requirements that include an income test of two hundred and fifty percent of the federal poverty guidelines, and diagnostic testing by a contracted CDC provider resulting in a diagnosis of breast or cervical cancer including pre-cancerous conditions. Women who have met CDC screening criteria and identified as needing treatment for a diagnosis of breast or cervical cancer, including pre-cancerous conditions will be referred for treatment that includes the completion of a medicaid application for the BCC program. The Breast and Cervical Cancer Prevention and Treatment Act allows states to extend presumptive eligibility to applicants in order to ensure that needed treatment begins as early as possible.
[8.252.400.9 NMAC - Rp 8.252.400.9 NMAC, 7/1/2024

8.252.400.10 BASIS FOR DEFINING THE GROUP: Women who have been determined as having met CDC program screening requirements will be identified and referred for treatment. Public Law 106-354 does not provide eligibility for men diagnosed with cancer.
[8.252.400.10 NMAC - Rp 8.252.400.10 NMAC, 7/1/2024

8.252.400.11 GENERAL RECIPIENT REQUIREMENTS: Eligibility for the breast and cervical cancer program is always prospective. Women must meet, or expect to meet, all medicaid and CDC financial and non-financial eligibility criteria in the month for which determination of eligibility is made.
[8.252.400.11 NMAC - Rp 8.252.400.11 NMAC, 7/1/2024

8.252.400.12 ENUMERATION: A woman must furnish her social security account number. Medicaid eligibility is denied or terminated for a woman who fails to furnish her social security number. If a woman does not have a valid social security number, she must apply for one as a condition of medicaid eligibility. Presentation of the application for a social security number, or proof that an application has been made at a social security administration office, meets this requirement. A woman must provide her social security account number upon receipt of the number from SSA but no later than her next recertification.
[8.252.400.12 NMAC - Rp 8.252.400.12 NMAC, 7/1/2024

8.252.400.13 CITIZENSHIP: Refer to 8.200.410.11 NMAC. Women who do not meet citizenship eligibility criteria may be eligible to receive coverage for emergency services under the emergency medical services for undocumented non-citizens (EMSNC) program.
[8.252.400.13 NMAC - Rp 8.252.400.13 NMAC, 7/1/2024

8.252.400.14 RESIDENCE: To be eligible for medicaid, a woman must be physically present in New Mexico on the date of application or final determination of eligibility and must have intent to remain in the state.

A. Establishing residence: Residence in New Mexico is established by living in the state and carrying out the types of activities normally indicating residency, such as occupying a home, enrolling child (ren) in school, getting a state driver's license, or renting a post office box. A woman who is homeless is considered to have met the residence requirements if she intends to remain in the state.

B. Recipients receiving benefits out-of-state: A women who receives medical assistance in another state is considered a resident of that state until the income support division (ISD) staff receives verification from the other state agency indicating that it has been notified by the woman of the abandonment of residence in that state.

C. Abandonment: Residence is not abandoned by temporary absences. Temporary absences occur when a woman leaves New Mexico for specific purposes with time-limited goals. Residence is considered abandoned when any of the following occurs:

(1) a woman leaves New Mexico and indicates that she intends to establish residence in another state;

(2) a woman leaves New Mexico for no specific purpose with no clear intention of returning;

(3) a woman leaves New Mexico and applies for financial, food or medical assistance in another state.

[8.252.400.14 NMAC - Rp 8.252.400.14 NMAC, 7/1/2024

8.252.400.15 NON-CONCURRENT RECEIPT OF ASSISTANCE: A woman may not be receiving assistance in another medicaid category.

[8.252.400.15 NMAC - Rp 8.252.400.15 NMAC, 7/1/2024

8.252.400.16 SPECIAL RECIPIENT REQUIREMENTS: A woman must have been screened and diagnosed with breast or cervical cancer or a pre-cancerous condition by a provider of the centers for disease control and prevention's (CDC) national breast and cervical cancer early detection program and be in need of treatment. Women identified as in need of treatment, will be given an application that includes the DOH's CDC contracted provider referral for treatment form. The DOH is responsible for verifying the referring physician is a contracted CDC provider.

[8.252.400.16 NMAC - Rp 8.252.400.16 NMAC, 7/1/2024

8.252.400.17 AGE: To be eligible for this category, a woman must be under 65 years of age. Medicaid eligibility ends the last day of the month a woman turns 65 years of age.

[8.252.400.17 NMAC - Rp 8.252.400.17 NMAC, 7/1/2024

8.252.400.18 THIRD PARTY LIABILITY: A woman must be uninsured.

A. A woman is considered uninsured when her health insurance policy has lifetime limits and she has exhausted those limits or she is denied coverage due to a pre-existing condition.

B. Women with high deductibles or limits on coverage, such as the limit of doctor visits or drug coverage that have not been exhausted, are considered insured.

C. There is no penalty for dropping insurance.

[8.252.400.18 NMAC - Rp 8.252.400.18 NMAC, 7/1/2024

8.252.400.19 PRESUMPTIVE ELIGIBILITY: A woman may be eligible to receive medicaid services from the date the presumptive eligibility determination is made until the end of the month following the month in which the determination was made, for a period of up to 60 days. The purpose of the presumptive eligibility is to allow medicaid payment for health care services furnished to a woman while her application for medicaid is being processed. Only one presumptive eligibility period is allowed per 12-month period. The period of presumptive eligibility begins when an approved presumptive eligibility provider establishes eligibility. Presumptive eligibility criteria are a simplified version of Category 052 eligibility requirements.

A. Processing presumptive eligibility information: The medical assistance division (MAD) authorizes certain providers to make presumptive eligibility determinations. The provider must notify MAD through its claims processing contractor of the determination within 24 hours of the determination of presumptive eligibility.

B. Provider responsibility: The presumptive eligibility provider must process both presumptive eligibility as well as an application for medical assistance for the woman.

C. Provider eligibility: Entities who may participate must be a CDC Title XV grantees are those entities receiving funds under a cooperative agreement with CDC to support activities related to the national breast and cervical cancer detection program.

[8.252.400.19 NMAC - Rp 8.252.400.19 NMAC, 7/1/2024

8.252.400.20 RECIPIENT RIGHTS AND RESPONSIBILITIES: A woman or her representative is responsible for establishing her eligibility for medicaid. As part of this responsibility, the woman must provide required information and documents, or take the actions necessary to establish eligibility. Failure to do so must result in a decision that eligibility does not exist. A woman must also grant the HCA permission to contact other persons, agencies or sources of information necessary to establish eligibility. See

8.200.430 NMAC, *Recipient Rights and Responsibilities* for specific information.
[8.252.400.20 NMAC - Rp 8.252.400.20 NMAC, 7/1/2024

8.252.400.21 REPORTING REQUIREMENTS: A woman or any other responsible party must:

A. report any changes in circumstances, which may affect the woman's eligibility within 10 days of the date of the change to the county ISD office;

B. the ISD worker must evaluate the effect of the change and take any required action as soon as possible; however, the action must take effect no later than the end of the month following the month in which the change took place.
[8.252.400.21 NMAC - Rp 8.252.400.21 NMAC, 7/1/2024

HISTORY OF 8.252.400 NMAC:
[**RESERVED**]

History of Repealed Material:
8.252.400 NMAC - Recipient Policies (filed 6/14/2002) Repealed 7/1/2024.

Other: 8.252.400 NMAC - Recipient Policies (filed 6/14/2002) Replaced by 8.252.400 NMAC - Recipient Policies effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 280 MEDICAID ELIGIBILITY - PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)
PART 500 INCOME AND RESOURCE STANDARDS

8.280.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.280.500.1 NMAC - Rp, 8.280.500.1 NMAC, 7/1/2024]

8.280.500.2 SCOPE: The rule applies to the general public.
[8.280.500.2 NMAC - Rp, 8.280.500.2 NMAC, 7/1/2024]

8.280.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.280.500.3 NMAC - Rp, 8.280.500.3 NMAC, 7/1/2024]

8.280.500.4 DURATION: Permanent.
[8.280.500.4 NMAC - Rp, 8.280.500.4 NMAC, 7/1/2024]

8.280.500.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.280.500.5 NMAC - Rp, 8.280.500.5 NMAC, 7/1/2024]

8.280.500.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.280.500.6 NMAC - Rp, 8.280.500.6 NMAC, 7/1/2024]

8.280.500.7 DEFINITIONS:
[**RESERVED**]

8.280.500.8 MISSION STATEMENT: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.280.500.8 NMAC - Rp, 8.280.500.8 NMAC, 7/1/2024]

8.280.500.9 NEED DETERMINATION: Eligibility for PACE is determined prospectively. Applicants/recipients must meet, or expect to meet, all financial eligibility criteria in the month for which a determination of eligibility is made. Applicants for and recipients of medicaid through PACE must apply for, and take all necessary steps to obtain, any income or resources to which they may be entitled. Such steps must be taken within 30 days of the date the HCA (HCA) furnishes notice of the potential entitlement. Failure or refusal to apply for and take all necessary steps to determine eligibility for other benefits after notice is received results in an applicant/recipient becoming ineligible for medicaid.

A. Applicants/ recipients who have elected a lower veterans affairs (VA) payment do not need to reapply for veteran's administration improved pension (VAIP) benefits.

B. Crime victims are not required to accept victim's compensation payments from a state-administered fund as a condition of medicaid eligibility.
[8.280.500.9 NMAC - Rp, 8.280.500.9 NMAC, 7/1/2024]

8.280.500.10 RESOURCE STANDARDS: See 8.281.500.10 NMAC and all following subsections.
[8.280.500.10 NMAC - Rp, 8.280.500.10 NMAC, 7/1/2024]

8.280.500.11 APPLICABLE RESOURCE STANDARDS: An applicant/recipient is eligible for medicaid on the factor of resources if countable resources do not exceed $2,000. See 8.281.500.11 NMAC.
[8.280.500.11 NMAC - Rp, 8.280.500.11 NMAC, 7/1/2024]

8.280.500.12 COUNTABLE RESOURCES: See 8.281.500.12 NMAC.
[8.280.500.12 NMAC - Rp, 8.280.500.12 NMAC, 7/1/2024]

8.280.500.13 RESOURCE EXCLUSIONS: See 8.281.500.13 NMAC.
[8.280.500.13 NMAC - Rp, 8.280.500.13 NMAC, 7/1/2024]

8.280.500.14 ASSET TRANSFERS: See 8.281.500.14 NMAC for regulations governing transfers of assets. All provisions pertaining to transfers under institutional care medicaid apply to transfers under PACE with the exception of the penalty for transfers without fair return. The penalty for transfers of assets without fair return for PACE applicants/recipients is ineligibility for medicaid under PACE.
[8.280.500.14 NMAC - Rp, 8.280.500.14 NMAC, 7/1/2024]

8.280.500.15 TRUSTS: See 8.281.500.15 NMAC.
[8.280.500.15 NMAC - Rp, 8.280.500.15 NMAC, 7/1/2024]

8.280.500.16 RESOURCE STANDARDS FOR MARRIED COUPLES: See 8.281.500.16 NMAC for spousal impoverishment methodology used in the determination of eligibility for married applicants/recipients with a spouse in the home who began receiving PACE services on or after September 30, 1989. A resource assessment is completed as of the first moment of the first day of the month in which the level of care is approved.
[8.280.500.16 NMAC - Rp, 8.280.500.16 NMAC, 7/1/2024]

8.280.500.17 DEEMING RESOURCES: Not applicable to PACE.
[8.280.500.17 NMAC - Rp, 8.280.500.17 NMAC, 7/1/2024]

8.280.500.18 INCOME: An applicant/recipient's gross countable monthly income must be less than the maximum allowable monthly income standard. See 8.281.500.18 NMAC.
[8.280.500.18 NMAC - Rp, 8.280.500.18 NMAC, 7/1/2024]

8.280.500.19 INCOME STANDARDS: See 8.281.500.19 NMAC.
[8.280.500.19 NMAC - Rp, 8.280.500.19 NMAC, 7/1/2024]

8.280.500.20 UNEARNED INCOME: See 8.281.500.20 NMAC.
[8.280.500.20 NMAC - Rp, 8.280.500.20 NMAC, 7/1/2024]

8.280.500.21 DEEMED INCOME: See 8.281.500.21 NMAC.
[8.280.500.21 NMAC - Rp, 8.280.500.21 NMAC, 7/1/2024]

8.280.500.22 DISREGARDS: See 8.281.500.22 NMAC.
[8.280.500.22 NMAC - Rp, 8.280.500.22 NMAC, 7/1/2024]

8.280.500.23 MEDICAL CARE CREDIT: There are medical care credits in PACE only when a PACE recipient enters a nursing facility. See 8.281.500.22 NMAC.
[8.280.500.23 NMAC - Rp, 8.280.500.23 NMAC, 7/1/2024]

HISTORY OF 8.280.500 NMAC:

History of Repealed Material:
8 NMAC 4.PAC.500, Income and Resource Standards, filed 1/20/1998 - Repealed effective 12/1/2006.
280.500 NMAC - Income And Resource Standards (filed 11/15/2006) Repealed effective 7/1/2024.

Other: 8.280.500 NMAC - Income And Resource Standards (filed 11/15/2006) Replaced by 8.280.500 NMAC - Income And Resource Standards effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 285 MEDICAID ELIGIBILITY - EMERGENCY MEDICAL SERVICES FOR NON-CITIZENS
PART 500 INCOME AND RESOURCE STANDARDS

8.285.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.285.500.1 NMAC - Rp 8.285.500.1 NMAC, 7/1/2024]

8.285.500.2 SCOPE: The rule applies to the general public.
[8.285.500.2 NMAC - Rp 8.285.500.2 NMAC, 7/1/2024]

8.285.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.285.500.3 NMAC - Rp 8.285.500.3 NMAC, 7/1/2024]

8.285.500.4 DURATION: Permanent.
[8.285.500.4 NMAC - Rp 8.285.500.4 NMAC, 7/1/2024]

8.285.500.5 EFFECTIVE DATE: July 1, 2024, unless a later date was cited at the end of a section.
[8.285.500.5 NMAC - Rp 8.285.500.5 NMAC, 7/1/2024]

8.285.500.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.285.500.6 NMAC - Rp 8.285.500.6 NMAC, 7/1/2024]

8.285.500.7 DEFINITIONS: [**RESERVED**]

8.285.500.8 MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.285.500.8 NMAC - Rp 8.285.500.8

NMAC, 7/1/2024]

8.285.500.9 NEED DETERMINATION: [**RESERVED**]
[8.285.500.9 NMAC - Rp 8.285.500.9 NMAC, 7/1/2024]

8.285.500.10 RESOURCE STANDARDS: Non-citizens who receive emergency services must meet the applicable resource standards for an existing medicaid category.
[8.285.500.10 NMAC - Rp 8.285.500.10 NMAC, 7/1/2024]

8.285.500.11 INCOME STANDARDS: Non-citizens who receive emergency services must meet the income standards for an existing medicaid category.
[8.285.500.11 NMAC - Rp 8.285.500.11 NMAC, 7/1/2024]

HISTORY OF 8.285.500 NMAC: [**RESERVED**]

History of Repealed Material: 8.285.500 NMAC - Income And Resource Standards (filed 11/17/2008) Repealed effective 7/1/2024.

Other: 8.285.500 NMAC - Income And Resource Standards (filed 11/17/2008) Replaced by 8.285.500 NMAC - Income And Resource Standards effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 285 MEDICAID ELIGIBILITY - EMERGENCY MEDICAL SERVICES FOR NON-CITIZENS
PART 600 BENEFIT DESCRIPTION

8.285.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.285.600.1 NMAC - Rp 8.285.600.1 NMAC, 7/1/2024]

8.285.600.2 SCOPE: The rule applies to the general public.
[8.285.600.2 NMAC - Rp 8.285.600.2 NMAC, 7/1/2024]

8.285.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.285.600.3 NMAC - Rp 8.285.600.3 NMAC, 7/1/2024]

8.285.600.4 DURATION: Permanent.
[8.285.600.4 NMAC - Rp 8.285.600.4 NMAC, 7/1/2024]

8.285.600.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.285.600.5 NMAC - Rp 8.285.600.5 NMAC, 7/1/2024]

8.285.600.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.285.600.6 NMAC - Rp 8.285.600.6 NMAC, 7/1/2024]

8.285.600.7 DEFINITIONS: [**RESERVED**]

8.285.600.8 MISSION STATEMENT: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.285.600.8 NMAC - Rp 8.285.600.8 NMAC, 7/1/2024]

8.285.600.9 BENEFIT DESCRIPTION: An applicant/recipient who is eligible for medicaid under this category is eligible for emergency services coverage only for the duration of the emergency.
[8.285.600.9 NMAC - Rp 8.285.600.9 NMAC, 7/1/2024]

8.285.600.10 BENEFIT DETERMINATION:

A. Subsequent to the receipt of emergency services, an applicant must apply through the local county income support division (ISD) office. The application must be filed at the ISD office no later than the last day of the third month following the month the presumed emergency services were received.

B. Documentation requirements: The applicant must bring a completed emergency medical services for non-citizens (EMSNC) referral for eligibility determination form (MAD 308) to the ISD office for the financial eligibility determination. The emergency services provider must complete the referral form.

C. Financial documents: The applicant must provide all necessary documentation to prove that they meet all financial and non-financial eligibility standards. Medical providers cannot submit eligibility applications on behalf of the applicant. The applicant is financially responsible for any services not covered by medicaid. A completed and signed application form must be submitted for each request for EMSNC.
[8.285.600.10 NMAC - Rp 8.285.600.10 NMAC, 7/1/2024]

8.285.600.11 INITIAL BENEFITS: Applications for medicaid must be acted on within 45 days of the date of application.

A. If an applicant is eligible for medicaid, the individual is sent a notice of case action (NOCA) form. The approval of financial eligibility is not a guarantee that medicaid will pay for the services. The NOCA form also serves as notice of case closure, since medicaid covers only emergency services received during the specified term of

the emergency. The provider is sent the decision for emergency medical services for non-citizens (EMSNC) application (MAD 778) form. The provider must use the MAD 778 form to submit claims to the medicaid utilization review contractor for emergency review.

B. If an applicant is ineligible for medicaid or a decision on the application is delayed beyond the 45 day time limit, the individual is sent a NOCA form regarding the application for EMSNC. The NOCA form explains the reason for denial or delay and informs the applicant of their right to an administrative hearing. If the application is denied, the applicant must notify providers of the denial.

C. The applicant is responsible for payment for the medical services if they fail to apply promptly for coverage, verify eligibility for coverage, or notify the provider of the approval or denial of the application.
[8.285.600.11 NMAC - Rp 8.285.600.11 NMAC, 7/1/2024]

8.285.600.12 ONGOING BENEFITS: No periodic review is necessary, since this category does not result in continuous eligibility. The eligibility for the specific period will only cover the bona fide emergency services. A medicaid card is not issued. No separate notice of case closure is necessary. Notice of approval serves as notice of closure as it indicates the specific period of eligibility. Medicaid covers emergency services only for the duration of the emergency, as determined by medicaid utilization review contractor.
[8.285.600.12 NMAC - Rp 8.285.600.12 NMAC, 7/1/2024]

8.285.600.13 RETROACTIVE COVERAGE: There is no retroactive coverage for this category.
[8.285.600.13 NMAC - Rp 8.285.600.13 NMAC, 7/1/2024]

HISTORY OF 8.285.600 NMAC:
[**RESERVED**]

History of Repealed Material:
8.285.600 NMAC - Benefit Description (filed 11/17/2008) Repealed effective 7/1/2024.

Other: 8.285.600 NMAC - Benefit Description (filed 11/17/2008) Replaced by 8.285.600 NMAC - Benefit Description effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 290 MEDICAID ELIGIBILITY - HOME AND COMMUNITY-BASED SERVICES WAIVER (CATEGORIES 090, 091, 092, 093, 094, 095 AND 096)
PART 500 INCOME AND RESOURCE STANDARDS

8.290.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.290.500.1 NMAC - Rp 8.290.500.1 NMAC, 7/1/2024]

8.290.500.2 SCOPE: The rule applies to the general public.
[8.290.500.2 NMAC - Rp 8.290.500.2 NMAC, 7/1/2024]

8.290.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Sections 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.290.500.3 NMAC - Rp 8.290.500.3 NMAC, 7/1/2024]

8.290.500.4 DURATION: Permanent.
[8.290.500.4 NMAC - Rp 8.290.500.4 NMAC, 7/1/2024]

8.290.500.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.290.500.5 NMAC - Rp 8.290.500.5 NMAC, 7/1/2024]

8.290.500.6 OBJECTIVE: The objective of these regulations is to provide eligibility criteria for the medicaid program.
[8.290.500.6 NMAC - Rp 8.290.500.6 NMAC, 7/1/2024]

8.290.500.7 DEFINITIONS: See 8.290.400.7 NMAC.
[8.290.500.7 NMAC - Rp 8.290.500.7 NMAC, 7/1/2024]

8.290.500.8 MISSION: To 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.
[8.290.500.8 NMAC - Rp 8.290.500.8 NMAC, 7/1/2024]

8.290.500.9 NEED DETERMINATION: Eligibility for the home and community-based services waiver programs is always prospective. Applicants/recipients must meet, or expect to meet, all financial eligibility criteria in the month for which a determination of eligibility is made. Applicants for and recipients of medicaid through one of the waiver programs must apply for, and take all necessary steps to obtain, any income or resources to which they may be entitled. Such steps must be taken within 30 days of the date the HCA furnishes notice of the potential entitlement.

A. Failure to apply for and take steps to determine eligibility for other benefits: Failure or refusal to apply for and take all necessary steps to determine eligibility for other benefits after notice is received results in an applicant/recipient becoming ineligible for medicaid.

B. Exceptions to

general requirement: Applicants/ recipients who have elected a lower VA payment do not need to reapply for veterans administration improved pension (VAIP) benefits. Crime victims are not required to accept victims compensation payments from a state-administered fund as a condition of medicaid eligibility.
[8.290.500.9 NMAC - Rp 8.290.500.9 NMAC, 7/1/2024]

8.290.500.10 RESOURCE STANDARDS: See 8.281.500.10 NMAC and following subsections.
[8.290.500.10 NMAC - Rp 8.290.500.10 NMAC, 7/1/2024]

8.290.500.11 APPLICABLE RESOURCE STANDARDS: An applicant/recipient is eligible for medicaid on the factor of resources if countable resources do not exceed $2,000.

A. Liquid resources: See Subsection A of 8.281.500.11 NMAC.

B. Nonliquid resources: See Subsection B of 8.281.500.11 NMAC and following subsections.
[8.290.500.11 NMAC - Rp 8.290.500.11 NMAC, 7/1/2024]

8.290.500.12 COUNTABLE RESOURCES: See 8.281.500.12 NMAC and following subsections.
[8.290.500.12 NMAC - Rp 8.290.500.12 NMAC, 7/1/2024]

8.290.500.13 RESOURCE EXCLUSIONS: See 8.281.500.13 NMAC and following subsections.
[8.290.500.13 NMAC - Rp 8.290.500.13 NMAC, 7/1/2024]

8.290.500.14 ASSET TRANSFERS: See 8.281.500.14 NMAC, *asset transfers*, and following subsections for rules governing transfers of assets. All provisions pertaining to transfers under institutional care medicaid apply to transfers under the waiver programs with the exception of the penalty for transfers of assets for less than fair market value. The penalty for transfers of assets for less than fair market value for waiver applicants/recipients is ineligibility for long term care medicaid services under the waiver programs. Federal regulations specify that, to be eligible for a waiver program, an individual must be receiving the waiver or long term care services. Because a waiver applicant/recipient is not eligible to receive these services under the medicaid program, they are ineligible for the HCBS waiver program. The period of ineligibility is based on when the assets were transferred during the look back period. After February 8, 2006, the look back period for transfers is 60 months prior to the date of application. As soon as the HCBS waiver applicant has no transfers for less than fair market value during the 60 months look back period, they are eligible to be reconsidered for HCBS provided all financial and non-financial criteria are met. If the transfer for less than fair market value is discovered after the applicant is approved for HCBS, the period of ineligibility begins the first day of the month in which the resources were transferred. If the applicant or recipient enters a nursing facility, a penalty period for the transfer of assets for less than fair market value is calculated based on 8.281.500.14, *asset transfers*. This penalty period runs whether or not the individual remains in the nursing facility.
[8.290.500.14 NMAC - Rp 8.290.500.14 NMAC, 7/1/2024]

8.290.500.15 TRUSTS: See 8.281.500.15 NMAC and following subsections.
[8.290.500.15 NMAC - Rp 8.290.500.15 NMAC, 7/1/2024]

8.290.500.16 RESOURCE STANDARDS FOR MARRIED COUPLES:

A. Community property resource determination methodology: See Subsection A of 8.281.500.16 NMAC and Paragraph (2) of Subsection A of 8.281.500.16 NMAC for methodology used in the determination of eligibility for married applicants/recipients who began receiving waiver services for a continuous period prior to September 30, 1989.

B. Spousal impoverishment: See Subsection B of 8.281.500.16 NMAC and following subsections for spousal impoverishment methodology used in the determination of eligibility for married applicants/recipients with a spouse in the home who began receiving waiver services on or after September 30, 1989. The resource assessment is completed as of the first moment of the first day of the month in which the level of care is approved.
[8.290.500.16 NMAC - Rp 8.290.500.16 NMAC, 7/1/2024]

8.290.500.17 DEEMING RESOURCES: See 8.281.500.17 NMAC. The resources of the custodial parent(s) are deemed available to the applicant/recipient for the entire calendar month in which the allocation letter is issued by the waiver program manager or the representative notifies the ISD worker that a UDR is available for the applicant/recipient. Beginning with the month following the month in which the allocation letter was issued, only the resources directly attributable and available to the applicant/ recipient are counted and compared to the resource limit.
[8.290.500.17 NMAC - Rp 8.290.500.17 NMAC, 7/1/2024]

8.290.500.18 INCOME: To qualify for medicaid under any of the waiver programs, the gross countable income of the applicant/recipient must be less than the maximum allowable monthly income standard. See 8.200.520.16 NMAC, Income Standards. See 8.281.500.18 NMAC and following subsections.
[8.290.500.18 NMAC - Rp 8.290.500.18 NMAC, 7/1/2024]

8.290.500.19 INCOME STANDARDS. Income exclusions: See 8.281.500.19 NMAC and following subsections.
[8.290.500.19 NMAC - Rp 8.290.500.19 NMAC, 7/1/2024]

8.290.500.20 UNEARNED INCOME: See 8.281.500.20 NMAC and following subsections.
[8.290.500.20 NMAC - Rp 8.290.500.20 NMAC, 7/1/2024]

8.290.500.21 DEEMED INCOME: See 8.281.500.21 NMAC and following subsections. The income of the custodial parent(s) is deemed available to the applicant/recipient for the entire calendar month in which the allocation letter is issued by the waiver program manager or the representative notifies the ISD worker that a UDR is available for the applicant/recipient. Beginning with the month following the month in which the allocation letter was issued, only the income directly attributable and available to the applicant/recipient is counted and compared to the income limit.
[8.290.500.21 NMAC - Rp 8.290.500.21 NMAC, 7/1/2024]

8.290.500.22 DISREGARDS: See 8.281.500.22 NMAC and following subsections.
[8.290.500.22 NMAC - Rp 8.290.500.22 NMAC, 7/1/2024]

8.290.500.23 POST ELIGIBILITY/MEDICAL CARE CREDIT: There are no medical care credits in the waiver programs. The applicant/recipient is allowed to keep all of their income to maintain their household in the community.
[8.290.500.23 NMAC - Rp 8.290.500.23 NMAC, 7/1/2024]

HISTORY OF 8.290.500 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the Commission of Public Records-State Records Center and Archives:
MAD Rule 898, Transfers Of Assets, 12/29/94.

History of Repealed Material:
8.290.500 NMAC - Income And Resource Standards (filed 4/16/2002) Repealed effective 7/1/2024.

Other: 8.290.500 NMAC - Income And Resource Standards (filed 4/16/2002) Replaced by 8.290.500 NMAC - Income And Resource Standards effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 300 MEDICAID GENERAL INFORMATION
PART 1 GENERAL PROGRAM DESCRIPTION

8.300.1.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.300.1.1 NMAC - Rp 8.300.1.1 NMAC, 7/1/2024]

8.300.1.2 SCOPE: The rule applies to the general public.
[8.300.1.2 NMAC - Rp 8.300.1.2 NMAC, 7/1/2024]

8.300.1.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended, and by state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.300.1.3 NMAC - Rp 8.300.1.3 NMAC, 7/1/2024]

8.300.1.4 DURATION: Permanent.
[8.300.1.4 NMAC - Rp 8.300.1.4 NMAC, 7/1/2024]

8.300.1.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.300.1.5 NMAC - Rp 8.300.1.5 NMAC, 7/1/2024]

8.300.1.6 OBJECTIVE: The objective of these rules is to provide policies for the service portion of the New Mexico medical assistance programs.
[8.300.1.6 NMAC - Rp 8.300.1.6 NMAC, 7/1/2024]

8.300.1.7 DEFINITIONS: [**RESERVED**]

8.300.1.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.
[8.300.1.8 NMAC - Rp 8.300.1.8 NMAC, 7/1/2024]

8.300.1.9 GENERAL PROGRAM DESCRIPTION: The HCA, through MAD, is responsible for the administration of the medicaid program and other health care programs. This joint federal and state program provides payment for medically necessary health services furnished to eligible recipients.
[8.300.1.9 NMAC - Rp 8.300.1.9 NMAC, 7/1/2024]

8.300.1.10 RELATIONSHIP TO MEDICARE: MAD covers medically necessary health services furnished to eligible recipients who meet specific income, resource and eligibility standards. Medicare is a federal program which offers health insurance coverage to eligible recipients 65 years of age or older, to those who have received disability benefits for 24 consecutive months, to those who have end stage renal disease, and to other eligible recipients, as specified by other provisions of the Social Security Act.

A. The state of New Mexico has entered into an agreement with the social security administration to pay medicaid eligible recipient premiums for medicare part B, and under some circumstances, medicare part A premiums.

B. After medicare has made payment for services, the medicaid program pays for the medicare co-insurance and deductible amounts for all eligible medicaid

recipients subject to the following medicaid reimbursement limitations.

(1) Medicaid payment for the co-insurance and deductible is limited such that the payment from medicare, plus the amount allowed by medicaid for the co-insurance and deductible, shall not exceed the medicaid allowed amount for the service. When the medicare payment exceeds the amount that medicaid would have allowed for the service, no payment is made for the co-insurance or deductible. The claim is considered paid in full. The provider may not collect any remaining portion of the medicare co-insurance or deductible from the eligible recipient or their personal representative. For services for which medicare part B applies a fifty percent co-insurance rate, medicare co-insurance and deductible amounts may be paid at an amount that allows the provider to receive more than medicaid allowed amount, not to exceed a percentage determined by HCA.

(2) The medicaid program will pay toward the medicare co-insurance and deductible to the extent that the amount paid by medicare and the allowed medicare co-insurance and deductible together do not exceed the medicaid allowed amount. The medicaid program will pay the medicare co-insurance and deductible when the medicaid program does not have a specific amount allowed for the service.

[8.300.1.10 NMAC - Rp 8.300.1.10 NMAC, 7/1/2024]

HISTORY OF 8.300.1 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

SP-001.0300, Section 1, Single State Agency Organization Statewide Operations, filed 1/15/1981.

SP-003.0200, Section 3, Services: General Provisions Coordination of Medicaid with Medicare Part B, filed 1/23/1981.

SP-004.0100, Section 4, General Program Administration Methods of Administration, filed 1/23/1981.

SP-004.0600, Section 4, General Program Administration Reports, filed 1/23/1981.

SP-003.0201, Coordination of Title XIX With Part B of Title XVIII, filed 2/25/1981.

SP-004.1000, Section 4, General Program Administration Free Choice of Providers, filed 3/3/1981.

SP-004.1200, Section 4, General Program Administration Consultation to Medical Facilities, filed 3/3/1981.

SP-004.1500, Section 4, General Program Administration Inspections of Care in Skilled Nursing and Intermediate Care Facilities and Institutions for Mental Diseases, filed 3/5/1981.

SP-004.1800, Section 4, General Program Administration Cost Sharing and Similar Charges, filed 3/5/1981.

SP-004.2500, Section 4, General Program Administration Program for Licensing Administrators of Nursing Homes, filed 3/5/1981.

SP-005.0100, Section 5, Personnel Administration Standards of Personnel Administration, filed 3/5/1981.

SP-005.0300, Section 5, Personnel Administration Training Programs, Subprofessional and Volunteer Programs, filed 3/5/1981.

SP-007.0100, Section 7, General Provisions Plan Amendments, filed 3/5/1981.

SP-001.0201, Section 1, Single State Agency Organization, Organization and Function of State Agency, filed 3/11/1981.

History of Repealed Material:

8.300.1 NMAC - General Program Description (filed 4/16/2004) Repealed effective 7/1/2024.

Other: 8.300.1 NMAC - General Program Description (filed 4/16/2004) Replaced by 8.300.1 NMAC - General Program Description effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES

CHAPTER 300 MEDICAID GENERAL INFORMATION

PART 2 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) POLICIES

8.300.2.1 ISSUING AGENCY: New Mexico Health Care Authority.

[8.300.2.1 NMAC - Rp 8.300.2.1 NMAC, 7/1/2024]

8.300.2.2 SCOPE: The rule applies to the general public.

[8.300.2.2 NMAC - Rp 8.300.2.2 NMAC, 7/1/2024]

8.300.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended, and by state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.300.2.3 NMAC - Rp 8.300.2.3 NMAC, 7/1/2024]

8.300.2.4 DURATION: Permanent.

[8.300.2.4 NMAC - Rp 8.300.2.4 NMAC, 7/1/2024]

8.300.2.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.

[8.300.2.5 NMAC - Rp 8.300.2.5 NMAC, 7/1/2024]

8.300.2.6 OBJECTIVE: The objective of this rule is to provide Health Insurance Portability and Accountability Act (HIPAA) instructions and policies for the New Mexico medical assistance programs.

[8.300.2.6 NMAC - Rp 8.300.2.6 NMAC, 7/1/2024]

8.300.2.7 DEFINITIONS: The following definitions apply to terms used in this chapter.

A. Alternate address: A location other than the primary address on file with HCA for the recipient or the recipient's personal representative.

B. Alternate means of communication: A communication made other than in writing on paper, or made orally to the recipient or their personal representative.

C. Amend or amendment: To make a correction to information that relates to the past, present, or future physical or mental health or condition of a recipient.

D. Authorized HCC employee: A person employed within the health care component (HCC) workforce who is authorized by the immediate supervisor or by HCC policies to perform the task.

E. Business associate: A person or entity that performs certain functions or services on behalf of the HCC involving the use or disclosure of individually identifiable health information. These include claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, and practice management. They also include, other than in the capacity of a member of the HCC workforce, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for the HCC.

F. Covered entity: A health plan, a health care clearinghouse, or a health care provider that transmits any health information in electronic form in connection with a recipient's health care transaction.

G. Disclose or disclosure: To release, transfer, provide access to, or divulge in any other manner (verbally, written, or electronic) protected health information outside the HCC workforce or to an HCC business associate.

H. Health care component (HCC): Those parts of the HCA, which is a "hybrid entity" under HIPAA 45CFR 164.105], that engage in covered health plan functions and business associate functions involving protected health information. HCA's health care component consists of the medical assistance division, supported by the income support division, the office of inspector general, the office of general counsel, and the office of the secretary.

I. Health care operations: Any of the following activities: quality assessment and improvement activities, credentialing activities, training, outcome evaluations, audits and compliance activities, planning, fraud and abuse detection and compliance activities, managing, and general administrative activities of the HCC, to the extent that these are related to covered health plan functions.

J. Health oversight agency: An agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant.

K. Health Insurance Portability and Accountability Act (HIPAA) privacy rule: The federal regulation Section 45 CFR part 160 and Subparts A and E of Part 164.

L. Health plan: The medicaid program under Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., and the state children's health insurance program (SCHIP) under Title XXI of the Social Security Act, 42 U.S.C. 1397, et seq.

M. HCC workforce: Permanent, term, temporary and part-time employees (classified or exempt), university/federal government placements, volunteers, contractors and others conducting data entry tasks, and contractors and other persons whose conduct and work activities are under the direct control of HCC.

N. Medical record or designated record set: Any HCC item, collection, or grouping of information that includes protected health information (PHI) that is written or electronic and is used in whole or in part, by or for HCC to make decisions about the recipient. This applies to:

(1) the medical records and billing records about the recipient maintained by or for the HCC;

(2) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for HCC; and

(3) this definition *excludes* HCC documents such as those related to accreditation compliance activities (e.g., JCAHO), quality assurance, continuous quality improvement, performance improvement, peer reviews, credentialing and incident reports, and investigations.

O. Minimum necessary: The least amount of information needed to accomplish a given task.

P. Notice of privacy practices, notice or NPP: The official HCA notice of privacy practices that documents for a recipient the uses and disclosures of PHI that may be made by HCC and the recipient's rights and HCC's legal duties with respect to PHI.

Q. Payment: All HCC activities undertaken in its role as a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan, and HCC activities undertaken to obtain or provide reimbursement for the provision of health care. Such activities include but are not limited to:

(1) determination of eligibility or coverage;

(2) risk adjusting amounts due based upon health status or demographic characteristics;

(3) billing, claims management, collection activities, and related health care data processing;

(4) review of health care services with respect to medical necessity, coverage, appropriateness of care, or justification of charges;

(5) utilization review activities; and

(6) disclosure to consumer reporting agencies of lawful elements of PHI relating to collection of premiums or reimbursement.

R. Personal representative: A person who has the legal right to make decisions regarding an eligible recipient's PHI, and includes surrogate decision makers, parents of unemancipated minors, guardians and treatment guardians, and agents designated pursuant to a power of attorney for health care.

S. Privacy and security officer (PSO): The individual appointed by HCA pursuant to HIPAA 45 CFR 164.530(a) who is responsible for development, implementation, and enforcement of the privacy policies and procedures required by HIPAA.

T. Protected health information (PHI): Health information that exists in any form (verbal, written or electronic) that identifies or could be used to identify a recipient (including demographics) and relates to the past, present, or future physical or mental health or condition of that recipient. It also includes health information related to the provision of health care or the past, present, or future payment for the provision of health care to a recipient.

U. Psychotherapy notes: Notes recorded (in any medium) documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the recipient's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

V. Public health agency: An agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.

W. Requestor: A recipient, personal representative of a recipient, or any other person making a request.

X. Restrict or restriction: To limit the use or disclosure of PHI for purposes of TPO, or for purposes of disclosing information to a spouse, personal representative, close family member or person involved with the eligible recipient's care.

Y. Standard protocols: A process that details what PHI is to be disclosed or requested, to whom, for what purpose, and that limits the PHI to be disclosed or requested to the amount reasonably necessary to achieve the purpose of the disclosure or request.

Z. TPO: Treatment, payment or health care operations.

AA. Treatment: The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a recipient; or the referral of a recipient for health care from one health care provider to another.

BB. Valid authorization: An authorization with all required elements, as specified in HIPAA privacy policy in Section 13 of 8.300.2 NMAC.

[8.300.2.7 NMAC - Rp 8.300.2.7 NMAC, 7/1/2024]

8.300.2.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.

[8.300.2.8 NMAC - Rp 8.300.2.8 NMAC, 7/1/2024]

8.300.2.9 GENERAL HIPAA APPLICATION AND INTERPRETATION: This part describes HIPAA policies including health plan responsibilities, disclosure requirements, minimum necessary, business associates, sanctions, reporting, and documentation requirements. The HCC shall meet all requirements in this chapter.

A. Medicaid is a health plan and a covered entity under HIPAA: The New Mexico medicaid program under title XIX of the Social Security Act qualifies as a health plan under HIPAA regulations at 45 CFR 160.103 and is considered a covered entity.

B. Inconsistency between state and federal law: In the event of any inconsistency between the federal HIPAA privacy rule and New Mexico statutes or regulations, the HIPAA privacy rule shall preempt state law, except where 45CFR 160.203]:

(1) a determination is made by the secretary of the United States department of health and human services pursuant to 45 CFR 160.204;

(2) the provision of state law relates to the privacy of individually identifiable health information and is more stringent than a standard, requirement, or implementation specification under

the HIPAA privacy rule;

(3) the provision of state law and procedures established thereunder provides for the reporting of disease or injury, child abuse, birth, or death, or for the conduct of public health surveillance, investigation or intervention; or

(4) the provision of state law requires the HCC to report, or to provide access to, information for the purpose of management audits, financial audits, program monitoring and evaluation, or the licensure or certification of facilities or individuals.

[8.300.2.9 NMAC - Rp 8.300.2.9 NMAC, 7/1/2024]

8.300.2.10 NOTICE OF PRIVACY PRACTICES: The HCA shall establish policies protecting a recipient's rights regarding HIPAA privacy practices 45CFR 164.520.

A. Notice of privacy practices requirements:

(1) HCA shall provide notice of privacy practices, update the notice as necessary, and distribute the notice and any revised notices to all recipients or their personal representatives.

(2) All notice of privacy practices required elements listed in the HIPAA privacy rule shall be contained in the HCA notice of privacy practices 45 CFR 164.520.

(3) The name of every recipient and, as applicable, their personal representative to whom the HCA notice of privacy practices is sent shall be recorded.

B. Notice schedule:

(1) For an eligible recipient enrolled in medicaid prior to July 1, 2003, a copy of the notice of privacy practices shall be sent to each eligible recipient's or their personal representative's last known address no later than November 1, 2003.

(2) For revisions made to the notice of privacy practices, a copy of the revised notice of privacy practices shall be mailed to each enrolled MAD eligible recipient or their personal representative within 60 calendar days of the effective date of the revision.

(3) For a new eligible recipient approved after July 1, 2003, a copy of the notice of privacy practices shall be mailed with the eligible recipient's new medicaid card or their eligibility determination notice.

(4) At least once every three years, HCA shall notify eligible recipients or their personal representatives by mail of the availability of the notice of privacy practices and how to obtain the notice of privacy practices.

[8.300.2.10 NMAC - Rp 8.300.2.10 NMAC, 7/1/2024]

8.300.2.11 RECIPIENT'S RIGHTS: HCA shall establish policies protecting a recipient's rights regarding HIPAA privacy practices.

A. Alternate means of communication: A recipient or their personal representative shall have the right to request an alternate means of communication and an alternative address to receive communications of protected health information (PHI) from the HCC. The HCC shall accommodate such requests when reasonable 45CFR 164.522(b).

(1) If the recipient or their personal representative is unable to write the request, the recipient or their personal representative may request assistance from the HCC. If assistance is provided, the HCC shall document that the assistance was given, have the recipient or their personal representative sign and date the document, co-sign and retain the document in the medical record.

(2) The HCC staff may determine the reasonableness of a request. If an HCC staff member is unable to determine if the request is reasonable, the staff member may request a supervisor's assistance.

(3) If the recipient or the recipient's personal representative is present when the request is approved or denied, HCC staff shall notify the recipient or the recipient's personal representative verbally of the decision, and shall document the notification in the recipient's file.

(4) If the recipient or their personal representative is not present when the request is approved or denied, HCC shall notify the recipient or their personal representative of the decision in writing and retain the copy of the decision in the recipient's file.

(5) If the request is approved, an HCC staff member shall record the alternative method or address in the medical record and in the PSO's database.

B. Inspect and copy: A recipient or their personal representative may inspect their own PHI in a medical file (designated record set) as maintained by the HCC. This does not include psychotherapy notes.

(1) For all requests received in writing, the HCC shall respond in writing to the request to inspect or to obtain a copy of HCC PHI no later than 60 calendar days after receipt of the request. The HCC shall then determine, using the criteria in HIPAA privacy rule, if the request will be granted in part, in full, or denied.

(a) If the request will be granted in full, the PSO shall provide a written response arranging with the recipient or their personal representative a convenient time and place to inspect or obtain a copy of the PHI, or may mail the copy of the PHI at the recipient's or their personal representative's request; and shall discuss the scope, format, and other aspects of the recipient's or their personal representative's request with the recipient or personal representative as necessary to facilitate timely provision.

(b) If the PSO is unable to gather the required data within the time period required, the PSO may extend the time for the action by no more than 30 calendar days so long as the recipient or their personal representative is provided with a written statement of the reason(s) for the delay and the date by which the PSO shall complete the action on the request. However,

only one such extension of time shall be allowed.

(c) The PSO shall provide a copy of the recipient's PHI to the recipient or their personal representative in the format requested, if possible. If not, the PSO shall provide the PHI in a readable hard copy form or in another format mutually agreed upon by the PSO and the recipient or their personal representative.

(2) If the request is denied, in part or in full, the PSO shall either:

(a) give the recipient or their personal representative access to any permitted PHI requested to the extent possible; or

(b) provide a written denial to the recipient or their personal representative; the denial shall be written in plain language and contain:

(i) the basis for the denial,

(ii) if applicable, a statement of the recipient's review rights, and

(iii) a description of how the recipient or their personal representative may complain to the PSO or to the secretary of HCA; this description shall include the title and telephone number of the PSO and the secretary of HCA.

(3) If the HCC does not maintain the PHI that is the subject of the request for inspection or copying, the PSO shall inform the recipient or their personal representative where to direct the request, if known.

(4) Exceptions: A recipient or their personal representative may not inspect the recipient's own protected health information (PHI) in a medical record in connection with:

(a) psychotherapy notes;

(b) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative proceeding;

(c) PHI maintained by the HCC that is subject to the clinical laboratory improvements amendments (CLIA) to the extent that access to the recipient or their personal representative is prohibited by CLIA;

(d) when the access to the PHI requested is reasonably likely to endanger the life or physical safety of the recipient or another person as determined by a licensed health care professional by using their professional judgment;

(e) when the PHI makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that granting the access requested is reasonably likely to cause substantial harm to such other person; or

(f) when the request for access is made by recipient's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the recipient or another person 45CFR 164.524.

(5) The PSO shall record all actions pertaining to access to inspect and copy

C. Accounting of disclosures: Accounting of all disclosures of a recipient's PHI shall be produced via written report by the PSO when the request is made in writing by the recipient or their personal representative and sent to the PSO.

(1) All disclosures shall be reported except for those:

(a) made to carry out TPO 45 CFR 164.506;

(b) for a facility directory;

(c) for notification purposes that include disaster relief, emergencies, or in the case of recipient death;

(d) for national security purposes;

(e) to correctional institutions or law enforcement officials having custody of an inmate;

(f) made prior to July 1, 2003;

(g) made more than six years prior to the date the accounting is requested;

(h) made to the recipient or their personal representative of the recipient's own PHI; or

(i) made to individuals involved in the recipient's care 45 CFR 164.528.

(2) If the HCC does not maintain the PHI that is the subject of the request for accounting, the PSO shall inform the recipient or their personal representative where to direct the request, if known.

(3) When a recipient or their personal representative requests in writing to the PSO an accounting of disclosures of PHI:

(a) within 60 calendar days of receiving a recipient's or their personal representative's request, HCC prepares a report from the PSO's database that includes all required PHI disclosures that occurred during the six years prior to the date of the request for an accounting, unless the recipient or their personal representative requested an accounting for a shorter period of time than six years.

(b) the deadline for producing the disclosure report may be extended for up to 30 calendar days, provided that a written statement is sent to the recipient citing the reasons for the delay and the date by which the accounting shall be received;

(c) the HCC must provide free of charge the first accounting report within any 12-month period; if additional requests for an accounting are made within the same 12-month period, the HCC shall notify the recipient or their personal representative if a fee will be charged for the additional copies;

(d) the accounting disclosure information is entered into the PSO's database.

D. Setting restrictions: A recipient or their personal representative may request restrictions on the uses and disclosures of their own protected health information (PHI) by submitting a request in writing to the HIPAA privacy and security officer (PSO).

(1) The PSO shall approve or deny requests for restriction(s) in writing within 15 calendar days.

(2) If the HCC does not maintain the PHI that is the subject of the request for setting restrictions, the PSO shall inform the recipient or their personal representative where to direct the request, if known.

(3) If a restriction is approved by the PSO, the information shall be entered into the PSO's database and the HCC shall not use or disclose the restricted PHI 45CFR 164.522(a).

(4) If the recipient or their personal representative is unable to write the request, the recipient or their personal representative may request assistance from the HCC. If assistance is provided, the HCC shall document that the assistance was given, have the recipient or their personal representative sign and date the document, co-sign and retain the document in the recipient's file.

(5) Limited use and disclosure of PHI is allowable when the recipient or their personal representative is not present for an emergency or because of the incapacity of the recipient or their personal representative.

(6) The HCC shall approve or deny the request as appropriate and ensure that the approval or denial of the restriction is entered into the medical record.

(7) If the restriction would involve more than a single location, the HCC staff worker shall send the request to the HIPAA privacy and security officer.

(8) The PSO shall inform the recipient or their personal representative in writing of the approval or denial of the request to restrict use and disclosure.

(9) The PSO shall document the restriction(s) in the PSO's database.

E. Amendments: It is the policy of the HCC that the HCC shall allow a recipient to request that an amendment be made to the recipient's own protected health information (PHI) contained in a designated record set as long as the PHI was originated by the HCC.

(1) A request for an amendment shall be submitted in writing to the PSO 45 CFR 164.526.

(2) If the HCC does not maintain the PHI that is the subject of the request for amending, the PSO shall inform the recipient or their personal representative where to direct the request, if known.

(3) Within five working days of receiving the recipient's or their personal representative's written request for an amendment, the PSO shall forward the request to the possessor of the PHI requested to be amended for a determination on whether to grant or deny, in whole or in part, the recipient's or their personal representative's request.

(4) The possessor of the PHI shall:

(a) review the recipient's or their personal representative's request for an amendment;

(b) determine whether to grant or deny, in whole or in part, the recipient's or their personal representative's request;

(c) within 45 calendar days of receiving the recipient's or their personal representative written request for an amendment from the PSO, inform the PSO of the decision to grant or deny, in whole or in part, the recipient's or their personal representative's request and the reason(s) for reaching the decision;

(d) within 60 calendar days of the original receipt of the recipient's or their personal representative's request for an amendment, the PSO shall inform the recipient or their personal representative of the decision to grant or deny the requested amendment in whole or in part; and

(e) if the PSO is unable to act on the amendment within the required 60 calendar day period, the time may be extended by no more that 30 calendar days, provided that the PSO provides the recipient or their personal representative with a written statement of the reasons for the delay and the date the action on the request will be completed.

(5) If the recipient's or their personal representative's request is granted in whole or in part:

(a) the possessor shall make the appropriate amendment to the recipient's PHI in the designated record set;

(b) the PSO shall inform the recipient or their personal representative that the amendment is accepted;

(c) the PSO shall obtain the recipient's or their personal representative's agreement and identification of persons that the HCC is to notify of the amendment; and

(d) the PSO shall provide the amendment to those persons identified by the recipient or their personal representative and to persons, including business associates, that the PSO knows have received the PHI that is the subject of the amendment and who may have relied, or could predictably rely, on such information to the detriment of the recipient.

F. Complaints and appeals: It is the policy of the HCC to receive, investigate and resolve complaints made by a recipient or their personal representative of alleged violations of the HIPAA privacy rule. Complaints shall be made in writing, specifying how the recipient's privacy rights have been violated, and submitted to the PSO or to the secretary of HCA 45 CFR

164.530(d)(1), (e), and (f).

(1) Within five working days of receipt of the complaint, the PSO shall initiate a HIPAA privacy investigation.

(2) The PSO shall enter the complaint into the PSO's database.

(3) Within 30 calendar days of contact by the PSO, the appropriate HCC staff shall conduct the HIPAA privacy investigation and prepares a written report to the PSO documenting the details of the HIPAA privacy investigation and the findings.

(4) Within 30 calendar days after receiving the written report from the appropriate HCC staff, the PSO shall determine the validity of the complaint and notify the recipient or their personal representative, the HCC supervisor and the HCC staff of the action taken. In consultation with the HCC supervisor, the PSO shall take appropriate action to mitigate the adverse effects of any unauthorized disclosure.

(5) For valid complaints, the PSO shall ensure that the appropriate disciplinary action and training are applied as per 8.300.2.24 NMAC.

(6) The PSO shall enter the HIPAA privacy investigation results into the PSO's database.

(7) If the recipient's or their personal representative's request pursuant to this section is denied in whole or in part, the PSO shall:

(a) provide recipient or their personal representative with a timely, written denial, which includes the reason for the denial;

(b) inform the recipient or their personal representative of the recipient's right to submit, and the procedure for submission of a written statement disagreeing with the denial and also inform the recipient or their personal representative that if no statement of disagreement is submitted, the recipient or their personal representative may request that the HCC provide the recipient's or their personal representative's request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment request;

(c) if necessary, prepare a written rebuttal to the recipient's or their personal representative's statement of disagreement and provide a copy to the recipient or their personal representative;

(d) identify the record or PHI and append to the designated record set the:

(i) recipient's or their personal representative's request for an amendment;

(ii) the HCC's denial of the request;

(iii) the recipient's or their personal representative's statement of disagreement, if any; and

(iv) the HCC's rebuttal, if any. [8.300.2.11 NMAC - Rp 8.300.2.11 NMAC, 7/1/2024]

8.300.2.12 USE AND GENERAL DISCLOSURES OF PROTECTED HEALTH INFORMATION: PHI shall be used or disclosed only by authorized HCC staff or contractors and only in accordance with HCC policies and procedures 45 CFR 164.502(a) and 45 CFR 164.530(i).

A. Making a disclosure when an authorization is required: When PHI is requested, an authorized HCC employee shall:

(1) determine if a valid authorization is presented. See 8.300.2.13 NMAC;

(2) determine the identity and authority of the requestor as per 8.300.2.21 NMAC;

(3) if a valid authorization is presented and the identity and authority of the requestor is verified, the HCC is authorized to disclose the PHI in accordance with the valid authorization's instructions;

(4) HCC shall retain the valid authorization in the recipient's file;

(5) the valid authorization and the disclosure shall be documented in the PSO's database;

(6) if the request is not accompanied by a valid authorization, the HCC shall determine if an exception to the authorization requirement applies; and

(7) if no exception applies, the HCC shall deny the request for disclosure of PHI, document the denial and instruct the requestor that a valid authorization shall be obtained from the recipient or their personal representative before MAD will disclose PHI.

B. Exceptions: A valid written authorization shall be required from a recipient or their personal representative before any use or disclosure of PHI, with the following exceptions:

(1) disclosures to the recipient or personal representative pursuant to their request 45 CFR 164.502(a)(1)(i);

(2) for purposes of TPO 45 CFR 164.502 and 506;

(3) when a consent, authorization, or other express legal permission in writing was obtained from the eligible recipient prior to July 1, 2003, and is on file in an HCC location that permits the use or disclosure of PHI 45 CFR 164.532; and

(4) when the use or disclosure of PHI is limited to the minimum necessary to or for the following:

(a) assist disaster relief agencies 45 CFR 164.510(b)(4);

(b) coroners, medical investigators, funeral directors, and organ procurement organizations as authorized by law 45 CFR 164.512(g) and (h);

(c) avert a serious and imminent threat to the health or safety of a person or the public 45CFR 164.512(j):

(d) health oversight activities 45CFR 164.512(d);

(e) disclosures required by law pursuant to a legal duty to disclose or report, such as for law enforcement purposes, child abuse or neglect, judicial or administrative proceedings, or workers compensation proceedings pursuant to a subpoena 45CFR 164.512(a), (c), (e) and (f):

(f) public health activities 45CFR 164.512(b):

(g) correctional institutions or law enforcement officials who have custody of an inmate 45CFR 164.512(k)(5):

(h) government agencies which administer a government program that provides public benefits, where the disclosure is necessary to coordinate, improve, investigate, or manage the program 45CFR 164.512(d)(1) and (3): or

(i) research purposes that have been granted a waiver of authorization by an appropriately constituted institutional review board (IRB), a privacy board or representation that the PHI is necessary for research purposes 45CFR 164.512(i).

[8.300.2.12 NMAC - Rp 8.300.2.12 7/01/2024]

8.300.2.13 AUTHORIZATIONS: When a disclosure is made as a result of an exception to an authorization being required, the authorized HCC employee shall follow the specific procedure established for that exception 45CFR 164.502(b), 45 CFR 164.508, 45 CFR 164.512, 45 CFR 164.532.

A. Treatment, payment, or health care operations (TPO):

(1) When conducting daily business that involves the use or disclosure of PHI, the HCC shall determine whether the use or disclosure is for TPO.

(2) If the person who requested the PHI is unknown, the HCC shall verify the identity and authority in accordance with 8.300.2.21 NMAC.

(3) The HCC shall apply the minimum necessary criteria to disclosures of PHI for payment or health care operations.

(4) The HCC shall ensure that there are no restrictions to the requested disclosure for PHI.

(5) The HCC shall use or disclose the minimum necessary PHI. The minimum necessary criteria do not apply to disclosures or requests by a health care provider for treatment purposes.

(6) Disclosures made for the purpose of providing TPO are not required to be documented.

B. Averting a serious threat:

(1) If in good faith and using professional judgment, the HCC determines that the use or disclosure of PHI is necessary to avert a serious and imminent threat to the health or safety of a person or the public.

(a) If the identity of the requestor is unknown, the HCC shall verify the identity and authority of the requestor in accordance with 8.300.2.21 NMAC.

(b) The HCC shall apply the minimum necessary criteria per 8.300.2.16 NMAC for disclosing PHI to prevent or lessen the threat.

(c) The HCC shall disclose the PHI only to person(s) reasonably able to prevent or lessen the threat, including the target of the threat.

(2) The disclosure of PHI shall be documented in the PSO's database.

C. Workers compensation:

(1) If the identity and authority of the requestor is unknown, the HCC shall verify the information as required per 8.300.2.21 NMAC.

(2) The HCC shall disclose the required PHI to the workers' compensation administration in accordance with the minimum necessary criteria.

(3) The disclosure of PHI shall be documented in the PSO's database.

D. Coroners, medical investigators, funeral directors, and organ procurement organizations: When the PHI request is from coroners, medical investigators, funeral directors, or organ procurement organizations, the HCC shall:

(1) if unknown, verify the identity and authority of the requestor as per 8.300.2.21 NMAC;

(2) apply the minimum necessary criteria per 8.300.2.16 NMAC;

(3) disclose the minimum necessary PHI. Disclosures to the coroner or medical investigator require a valid subpoena; and

(4) record the disclosure in the PSO's database.

E. Disaster relief efforts: When an entity in disaster relief efforts requests PHI to assist in notifying, identifying, or locating a family member, personal representative or other person responsible for the care of the recipient regarding the recipient's location, general condition or death, the HCC shall:

(1) if unknown, verify the identity and authority of the requestor as per 8.300.2.21 NMAC;

(2) apply the minimum necessary criteria per 8.300.2.16 NMAC;

(3) provide recipients or their personal representatives the opportunity to agree to, restrict, or prohibit the use or disclosure of PHI to the disaster relief entity, unless the recipient is not present or is unable to agree to, restrict, or prohibit the disclosure; and

(4) record the disclosure in the PSO's database.

F. Health oversight activities: The health oversight agency may request documents related to a recipient's PHI and record the identity of recipients for whom PHI was accessed. The HCC shall

then:

(1) if unknown, verify the identity and authority of the requestor as per 8.300.2.21 NMAC;

(2) apply the minimum necessary criteria per 8.300.2.16 NMAC;

(3) disclose the minimum necessary PHI;

(4) obtain the identity of recipients for whom PHI was accessed; and

(5) record the disclosure in the PSO's database.

G. Public health activities: A public health agency may request documents related to a recipient's PHI. The HCC shall then:

(1) if unknown, verify the identity and authority of the requestor as per 8.300.2.21 NMAC;

(2) apply the minimum necessary criteria per 8.300.2.16 NMAC;

(3) disclose the minimum necessary PHI if the purpose of requesting the information is for:

(a) the prevention or control of disease, injury, or disability including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health interventions; or, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority;

(b) another public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;

(c) a person subject to the jurisdiction of the food and drug administration:

(i) to report adverse events (or similar reports with respect to food or dietary supplements), product defects or problems (including problems with the use or labeling of a product), or biological product deviations if the disclosure is made to the person required or directed to report such information to the food and drug administration;

(ii) to track products if the disclosure is made to a person required or directed by the food and drug administration to track the product;

(iii) to enable product recalls, repairs, or replacement (including locating and notifying individuals who have received products subject to recalls, withdrawals, or other problems); or

(iv) to conduct postmarketing surveillance to comply with requirements or at the direction of the food and drug administration, or

(d) a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.

(4) record the disclosure in the PSO's database.

H. Required by law:

(1) If the request for the disclosure of PHI appears to be required by law, the HCC shall verify the identity of the requestor and forward the request to the HCA office of general counsel (OGC) for a determination of the validity of the request.

(2) If advised by OGC that the request is valid, the HCC shall disclose the PHI in accordance with the minimum necessary criteria.

(3) The HCC shall record the disclosure in the PSO's database.

I. Law enforcement requests: When the disclosure of PHI is for law enforcement purposes, the HCC shall:

(1) verify identity and authority of the requestor;

(2) forward the request to OGC for a determination of the validity of the request;

(3) if advised by OGC that the request is valid, disclose the PHI in accordance with the minimum necessary criteria; and

(4) record the disclosure in the PSO's database.

J. Legal requests:

(1) If the request for PHI arises from legal proceedings and requests such as judicial or administrative proceedings or subpoenas, the HCC shall verify the identity of the requestor if practicable, and forward the request to OGC, unless documented exceptions from OGC have been received.

(2) If the identity of the requestor has not been previously verified to OGC, the HCC shall verify the identity of the requestor and determine the validity of the legal or law enforcement request.

(3) The HCC shall then disclose the PHI or direct the disclosure to be made.

(4) The HCC shall record the disclosure in the PSO's database.

K. When consent or authorization for the use or disclosure of PHI was made prior to July 1, 2003:

(1) The HCC shall determine if a valid authorization exists for the specific use or disclosure of PHI request.

(2) If a valid authorization does not exist, the HCC shall determine if a consent, an authorization, or other legal permission exists that was obtained before July 1, 2003.

(3) If a consent, an authorization, or other legal permission exists, the HCC shall verify that it is still in effect and that it is for the use or disclosure of the specific PHI requested.

(a) If yes, the HCC shall disclose the PHI and record the disclosure in the PSO's database.

(b) If no, the HCC shall deny the PHI request and instruct the requestor that a valid authorization must be obtained from the recipient. The requestor shall be provided a blank authorization form to be completed by recipient.

[8.300.2.13 NMAC - Rp 8.300.2.13 NMAC, 7/1/2024]

8.300.2.14 DISCLOSURES FOR RESEARCH PURPOSES:

A. Before a disclosure is made for research purposes, a valid authorization must be signed by the recipient or a waiver of authorization must have been obtained from a properly constituted institutional review board (IRB), a privacy board or representation that the PHI is necessary for research purposes 45CFR 164.512(i)(l); 45 CFR 164.514(b) and (e).

B. Disclosure requirements: The HCC shall:

(1) accept requests for PHI for research purposes with an authorization; or without a recipient authorization where the research entity provides documentation reflecting alteration or waiver of the authorization requirement 45CFR 164.512(i)(1) and (2):

(2) forward all requests to the PSO;

(3) if the requestor is unknown, verify the identity and authority of the requestor in accordance with 8.300.2.21 NMAC;

(4) grant or deny requests in accordance with the HIPAA privacy rule 45CFR 164.512(i): and

(5) enter the disclosure information into the PSO's database.

[8.300.2.14 NMAC - Rp 8.300.2.14 NMAC, 7/1/2024]

8.300.2.15 RECORDING AUTHORIZATIONS AND DISCLOSURES: The HCC shall record all valid authorizations and record all disclosures of PHI.

A. Recording of authorizations: All valid authorizations shall be recorded when received in the PSO's database 45CFR 164.508(b)(6). Any disclosures of PHI shall be made and recorded only by authorized members of the HCC workforce in the PSO's database.

B. Exceptions: The only exceptions that shall be allowed to the recording of disclosures of PHI are those:

(1) made to carry out TPO;

(2) for notification purposes that include disaster relief, emergencies, or in the case of recipient death;

(3) for national security purposes;

(4) to correctional institutions or law enforcement officials having custody of an inmate;

(5) made prior to July 1, 2003 45CFR 164.528a:

(6) made six years prior to the date the accounting is requested;

(7) made to the recipient of the recipient's own PHI; or

(8) made to individuals involved in the recipient's care.

[8.300.2.15 NMAC - Rp 8.300.2.15 NMAC, 7/1/2024]

8.300.2.16 MINIMUM NECESSARY: The HCC shall apply minimum necessary criteria to limit PHI for the use, disclosure, or request for PHI to the amount necessary to accomplish the task, except for disclosures to or requests by a health care provider for treatment purposes. The minimum necessary criteria do not apply with respect to disclosures to or requests by a health care provider for treatment. 45CFR 164.514(d)(2)-(5), 45 CFR 164.502(b)(2).

A. HCC's use of protected health information:

(1) An HCC supervisor shall determine the minimum necessary PHI needed by each HCC employee to perform their job duties and shall:

(a) grant appropriate medical record access;

(b) grant appropriate access to billing and payment information;

(c) grant appropriate access to other files containing PHI; or

(d) grant appropriate electronic access to PHI and set security levels.

(2) Members of the HCC authorized workforce shall use PHI as authorized. Requests for additional access to PHI shall be forwarded to the supervisor if needed to perform job duties.

B. HCC disclosures of protected health information:

(1) Prior to making any disclosures of PHI, an authorized HCC employee shall determine the minimum necessary PHI to disclose by applying the following.

(a) If the disclosure request is made for a medical record maintained within the supervisor's organizational unit, the request must specifically justify in writing why the entire medical record is needed. The HCC employee shall apply professional judgment in determining whether all PHI requested is necessary to be disclosed. Absent such justification, the request shall be denied. The written request and disposition shall be maintained within the medical record.

(b) If a request for PHI to be disclosed is pursuant to a state or federal statute, administrative rule, court order, contract or grant and the disclosure is routine or recurring, the HCC employee shall determine if a MAD protocol for that disclosure exists.

(c) If it does, the HCC employee shall follow the protocol established for that routine and recurring disclosure.

(d) For any other routine or recurring disclosures, the HCC employee shall contact the PSO with a proposed standard protocol that details the minimum necessary PHI to be disclosed, to whom and for what purpose. Once developed and approved, the HCC employee shall follow the protocol established for such routine and recurring disclosures. By following such protocol, the minimum necessary requirement will be met.

(e)

If the disclosure is not routine or recurring, the minimum necessary PHI to disclose is the PHI that has been requested by any of the following:

(i) a health care provider or health plan;

(ii) a business associate of the HCC, if the business associate represents that the PHI is the minimum necessary needed; or

(iii) a researcher whose request for PHI is consistent with the documentation of approval of such research by an IRB or privacy board, and which documentation was provided to, and approved by the PSO, in accordance with 8.300.2 NMAC and 45CFR 164.512(h).

(2) When determining the minimum necessary PHI for all other disclosures, the HCC shall:

(a) review each request and if necessary make appropriate inquiries of the requestor to determine why the PHI is needed;

(b) apply professional judgment in determining whether all of the PHI requested is necessary to be disclosed to accomplish the identified purpose of the requested disclosure;

(c) limit the disclosure to the appropriate PHI to accomplish the identified purpose;

(d) if the disclosure is less than requested, provide an explanation of the limitation.when the disclosure is made;

(e) refer questions concerning the minimum necessary disclosure of PHI to the PSO;

(f) if proposed standard protocols are received, the PSO reviews and approves or disapproves the standard protocol, keeps a copy of all approved standard protocols and notifies the supervisor of the decision; and

(g) authorized HCC employees shall:

(i) follow the standard protocols that have been approved by the PSO;

(ii) forward the request to their immediate supervisor, if disclosure requests are received other than from the recipient;

(iii) provide the minimum necessary PHI that the recipient requested, if the disclosure request is from the recipient; and

(iv) record the disclosure in the PSO's database.

C. HCC requests for protected health information: HCC employees shall determine the minimum necessary PHI to request by applying the following guidelines.

(1) If the request is made for a medical record, the request shall specifically justify why the entire medical record is needed. If the medical record is disclosed to or requested by a health care provider for treatment purposes, minimum necessary does not apply and justification is not required.

(2) If the request for PHI is not routine or recurring, the request shall be limited to the minimum necessary PHI to accomplish the task.

(3) All requests for PHI shall be in writing and a copy given to the PSO for audit purposes.

(4) For any PHI requests that are routine or recurring, employees shall send the proposed standard protocol to the PSO that details the minimum necessary PHI needed to accomplish the task.

(5) The PSO shall maintain written PHI requests and perform audits as necessary.

(6) If proposed standard protocols are received, the PSO shall review and approve or disapprove the standard protocol, keep a copy of all approved standard protocols, and notify the supervisor of the decision.

[8.300.2.16 NMAC - Rp 8.300.2.16 NMAC, 7/1/2024]

8.300.2.17 DE-IDENTIFICATION OF PROTECTED HEALTH INFORMATION: The HCC may de-identify PHI on recipients by removing all recipient identifiable information 45CFR 164.514(a) (b). Authorized HCC employees shall forward the PHI to be de-identified to a person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods for rendering information not individually identifiable; or they shall remove all the following recipient identifiable information.

A. Names.

B. Location: All geographic subdivisions smaller than a state, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the bureau of the census:

(1) the geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and

(2) the initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

C. Dates: All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

D. Numbers: All elements of numbers, or combination of alpha-numeric and special characters, for identification directly related to an individual, including:

(1) telephone numbers;

(2) fax numbers;

(3) e-mail addresses;

(4) social

security numbers;

(5) medical record numbers;

(6) health plan beneficiary numbers;

(7) account numbers;

(8) certificate/ license numbers;

(9) vehicle identifiers and serial numbers, including license plate numbers;

(10) device identifiers and serial numbers;

(11) web universal resource locators; (URLs);

(12) internet protocol (IP) address numbers;

(13) any other unique identifying number, characteristic, or code, except as otherwise permitted.

E. Imagery: All elements of physical characteristics captured in any format, or combination of formats, for identification directly related to an individual, including:

(1) biometric identifiers, including finger and voiceprints; and

(2) full face photographic images and any comparable images.

[8.300.2.17 NMAC - Rp 8.300.2.17 NMAC, 7/1/2024]

8.300.2.18 TERMINATION OF RESTRICTIONS:

A. Termination requirements: Restrictions on the uses and disclosures of PHI shall be terminated if:

(1) the recipient or the recipient's personal representative requests the termination in writing;

(2) the PSO informs the recipient or the recipient's personal representative in writing that the HCC agreement to a restriction has ended and that the termination of the restriction is effective with any PHI created or received after the recipient or the recipient's personal representative is notified of the termination 45CFR 164.522(a)(2): or

(3) if the recipient is unable to write the request, the recipient may request assistance from HCC; if assistance is provided, HCC shall document that the assistance was given, have the recipient sign and date the document, co-sign and retain the document in the medical record.

B. Consideration of request:

(1) The PSO shall approve or deny the request within five working days. If approved, the PSO shall notify the recipient or the recipient's personal representative in writing of the termination request and give the recipient or the recipient's personal representative 10 working days to disagree in writing; if denied, the PSO shall notify the requestor in writing.

(2) If the recipient or the recipient's personal representative disagrees, the PSO shall inform the requestor of the disagreement and require a response in three working days to review the communication from the recipient or the recipient's personal representative to ascertain if the disagreement by the recipient has bearing on the PSO final decision to terminate the restriction.

(3) The PSO shall issue a final decision within five working days and notify the recipient or personal representative and the MAD requestor.

(4) The PSO shall record the termination of restriction in the PSO's database.

[8.300.2.18 NMAC - Rp 8.300.2.18 NMAC, 7/1/2024]

8.300.2.19 BUSINESS ASSOCIATES: The HCC shall have privacy protections in all contracts if the contract anticipates that HCC will make disclosures of PHI to the contractor so that the contractor may use the PHI to perform a business associate function on behalf of MAD relating to TPO. The written protections shall satisfy HIPAA privacy rule 45 CFR 164.504(e).

[8.300.2.19 NMAC - Rp 8.300.2.19 NMAC, 7/1/2024]

8.300.2.20 MITIGATION:

A. HCC workforce: To the extent practicable, the HCC shall mitigate any harmful effect that is known to the HCC from an improper use or disclosure of a recipient's PHI by an HCC employee by applying the requirements set forth in the HCA HIPAA privacy policies and procedures applicable to an HCC workforce disciplinary action and training 45CFR 164.530(f). See 8.300.2 23 and 8.300.2.24 NMAC.

B. Business associates: To the extent practicable, the HCC will mitigate any harmful effect that is known to it from an improper use or disclosure of a recipient's PHI by any of its business associates by including language in its contracts with business associates that may impose fines and penalties to the business associate, up to and including immediate termination of a business associate's relationship with the HCC 45CFR 164.530(f).

[8.300.2.20 NMAC - Rp 8.300.2.20 NMAC, 7/1/2024]

8.300.2.21 VERIFYING IDENTITY AND AUTHORITY: If the identity or authority of a requestor of PHI is unknown, the identity and authority of that requestor shall be verified prior to any disclosure 45CFR 164.514(h).

A. Identification: Upon receipt of a request for PHI, an authorized HCC employee must determine whether the requestor is a recipient or personal representative of a recipient.

(1) If the requestor is unknown to the authorized HCC employee, the employee shall request proof of identity, such as a photograph ID, credit card issued to the requestor, or medicaid card issued to the requestor.

(2) If the request is made over the phone, the HCC employee shall require proof of identity by asking for a social security number or omnicaid system ID.

(3) If the requestor is the recipient, a valid signed authorization satisfies the authority requirement.

(4) If the requestor is the recipient's personal representative, the HCC employee

shall require proof of authority to act on the recipient's behalf.

(5) If the request for PHI disclosure is by a government official, and the government official's identity is unknown, the HCC employee shall verify the identity of the government official by viewing an agency identification badge or other official credentials.

(6) The HCC employee shall forward all requests for PHI for research purposes to the PSO. See 8.300.2.14 NMAC.

B. Authority: Once the identity of the government official is verified (or if already known), the HCC employee shall verify the authority of the request. If the disclosure of PHI is required by law, the employee shall disclose the PHI and record the disclosure in the PSO's database. If there are questions as to whether PHI disclosure is required by law, the employee shall seek assistance from OGC prior to any PHI disclosure.

(1) HCC shall forward all requests for PHI from subpoenas, legal requests, or for law enforcement purposes to OGC within two working days.

(2) For any requests for PHI received, OGC shall determine the identity of the requestor and the authority of the requestor. OGC then shall approve or deny the request and take the appropriate legal action.

C. Restrictions or amendments: If a valid authorization from an ISD location is received because a restriction or amendment is recorded in the PSO's database, the HCC shall take the following action.

(1) If a restriction is already documented, and the valid authorization from the recipient is asking for the restricted PHI to be disclosed, the HCC shall notify the recipient in writing within three working days that a previously set restriction must be revoked in writing by the recipient before the disclosure can be made.

(2) If an amendment is requested, within three working days the HCC shall determine if the PHI to be disclosed has been amended. If yes, the HCC shall disclose the amended PHI.

(3) The HCC shall record the disclosure in the PSO's database.

[8.300.2.21 NMAC - Rp 8.300.2.21 NMAC, 7/1/2024]

8.300.2.22 SAFEGUARDING PROTECTED HEALTH INFORMATION: PHI shall be confidential and shall be subject to safeguarding procedures. PHI shall be restricted from the public 45CFR 164.530(c).

A. Restricting access to PHI: When meeting with recipients or their personal representative, HCC employees shall ensure that any PHI that does not belong to that recipient is not visible. If meeting with the general public, HCC employees shall ensure that no PHI is accessible or visible.

B. Computer monitors: The HCC workforce shall:

(1) ensure that all computer monitors that provide access to PHI that are located in an area accessible to or visible by the general public are not facing the public; and

(2) ensure that each computer monitor that provides access to PHI is locked with a password-protected screen saver or otherwise secure the computer monitor by a method approved by the PSO before leaving the computer monitor for any reason.

C. Facsimile machines: The HCC workforce shall:

(1) when a fax machine is located in an area accessible by the general public, remove incoming and outgoing faxes immediately; and

(2) prior to sending any fax document containing PHI, verify the disclosure is in accordance with 8.300.2.12 NMAC;

(a) apply the minimum necessary criteria in accordance with 8.300.2.16 NMAC;

(b) verify that the number to which the PHI is being sent is the correct number;

(c) determine if the disclosure is required to be recorded, in accordance with 8.300.2.15 NMAC; and

(d) record any required disclosure of PHI in the PSO's database in accordance with 8.300.2.15 NMAC.

D. Electronic mail: Prior to sending an e-mail that contains PHI, the HCC workforce shall:

(1) verify the disclosure is in accordance with 8.300.2.15 NMAC;

(2) apply the minimum necessary criteria in accordance with 8.300.2.16 NMAC;

(3) enter a notation referring to the confidential or sensitive nature of the information in the subject line to further safeguard the confidentiality of electronically submitted data;

(4) verify the recipient's e-mail address; and

(5) determine if the disclosure is required to be recorded in the PSO's database in accordance with 8.300.2.15 NMAC, and if so, record it.

E. Document disposal: When documents that contain PHI that are no longer needed and are not required to be retained under state of New Mexico records and archives requirements, authorized members of the HCC workforce shall request such records be destroyed in accordance with 1.13.30.9 NMAC.

(1) HCC workforce members shall destroy any form of paper that contains PHI by shredding or equivalent means as approved by the PSO. If a shredder is not available at the time the paper containing PHI needs to be destroyed, the papers shall be placed in a secure, locked environment until a shredder is available.

(2) Under no circumstances shall un-shredded paper containing PHI be placed in a trashcan, recycle bin or otherwise disposed of.

F. Physical security: The HCC shall have in place appropriate physical safeguards to

protect the privacy of protected health information 45CFR 164.530(c).

G. Violations:

(1) The PSO shall perform random audits to assure compliance with this procedure and shall report any confirmed violation to the HCC workforce member's supervisor/coordinator.

(2) The PSO shall implement the appropriate disciplinary action and training (if applicable) described in 8.300.2.24 NMAC and record the confirmed violation and disciplinary action into the employee's file in the HCA office of human resources.

[8.300.2.22 NMAC - Rp 8.300.2.22 NMAC, 7/1/2024]

8.300.2.23 STAFF TRAINING: All members of the HCC workforce shall be trained within appropriate timeframes on HIPAA privacy policies and procedures regarding the proper use and disclosure of PHI 45CFR 164.530(b).

A. Initial training: The HCC shall:

(1) develop a training plan with HCC supervisory staff involvement to determine the timing of and level of training appropriate to members of the HCC workforce;

(2) develop bureau-specific training curricula and materials; the training material shall be maintained for six years;

(3) provide bureau-specific training for the current HCC workforce no later than July 1, 2003; and

(4) ensure documentation of initial training completion and forward documentation to the HCA office of human resources.

B. Continuous training: For HCC workforce members who begin employment or whose job functions change subsequent to July 1, 2003, HCC shall:

(1) within one working day of start date, notify the PSO of the new HCC workforce member, and schedule training for the new workforce member to be completed within 10 working days of the start date;

(2) for HCC workforce members whose job functions change, and who thus require a new level of training, notify the PSO and schedule the training prior to having the workforce member assume the new job duties; employees must successfully complete training within 10 working days of their start date, and evidence of training must be provided to the HCA office of human resources; and

(3) the HCA office of human resources shall retain the original signed training documentation for six years.

C. Privacy policy changes: When changes are made to HCC policies or procedures or when HCC changes its privacy practices 45CFR 164.530(b)], HCC shall:

(1) prepare relevant changes to the bureau-specific curricula;

(2) prepare changes to training materials;

(3) retain the training material for six years;

(4) after determining affected staff with supervisor involvement, develop a training plan;

(5) ensure that the HCC workforce successfully completes training and provide individual signed documentation of training to the PSO;

(6) the PSO shall forward the individual documentation of training to the HCA office of human resources; and

(7) the HCA office of human resources shall retain the original signed training documentation for six years.

[8.300.2.23 NMAC - Rp 8.300.2.23 NMAC, 7/1/2024]

8.300.2.24 [**RESERVED**]

8.300.2.25 [**RESERVED**]

8.300.2.26 [**RESERVED**]

8.300.2.27 [**RESERVED**]

8.300.2.28 [**RESERVED**]

HISTORY OF 8.300.2 NMAC: [**RESERVED**]

History of Repealed Material: 8.300.2 NMAC - Health Insurance Portability And Accountability Act Of 1996 (Hipaa) Policies (filed 6/16/2003) Repealed 7/1/2024.

Other: 8.300.2 NMAC - Health Insurance Portability And Accountability Act Of 1996 (Hipaa) Policies (filed 6/16/2003) Replaced by 8.300.2 NMAC - Health Insurance Portability And Accountability Act Of 1996 (Hipaa) Policies effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 300 MEDICAID GENERAL INFORMATION
PART 6 RESPONSIBILITY AND DELEGATION OF AUTHORITY

8.300.6.1 ISSUING AGENCY: New Mexico Health Care Authority.

[8.300.6.1 NMAC - Rp 8.300.6.1 NMAC, 7/1/2024]

8.300.6.2 SCOPE: The rule applies to the general public.

[8.300.6.2 NMAC - Rp 8.300.6.2 NMAC, 7/1/2024]

8.300.6.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended, or by state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 2007). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health

care facility licensure and health care purchasing and regulation.
[8.300.6.3 NMAC - Rp 8.300.6.3 NMAC, 7/1/2024]

8.300.6.4 DURATION: Permanent.
[8.300.6.4 NMAC - Rp 8.300.6.4 NMAC, 7/1/2024]

8.300.6.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.300.6.5 NMAC - Rp 8.300.6.5 NMAC, 7/1/2024]

8.300.6.6 OBJECTIVE: The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs.
[8.300.6.6 NMAC - Rp 8.300.6.6 NMAC, 7/1/2024]

8.300.6.7 DEFINITIONS: [**RESERVED**]

8.300.6.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.
[8.300.6.8 NMAC - Rp 8.300.6.8 NMAC, 7/1/2024]

8.300.6.9 RESPONSIBILITY AND DELEGATION OF AUTHORITY TO DIVISION: MAD administers the state medicaid program and other health care programs. MAD pays for medically necessary services furnished to eligible recipients who qualify for public assistance programs, institutional care programs, and optional programs under federal Social Security Act and other designated programs. See 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 2007). Coverage of services by medicaid is based on the federal Social Security Act, as amended, and subject to the appropriations and availability of federal and state funds. Administration may be provided through designated contractors and other state agencies.
[8.300.6.9 NMAC - Rp 8.300.6.9 NMAC, 7/1/2024]

8.300.6.10 STATUS OF PROVIDER TO HEALTH CARE AUTHORITY: A provider, its agents and employees are independent contractors who perform professional services for eligible recipients served through health care programs administered by HCA or its authorized agents and are not employees of HCA, or the state of New Mexico. A provider shall not purport to bind either HCA or the state of New Mexico to any obligation not expressly authorized, unless HCA has given the provider express written permission to do so.
[8.300.6.10 NMAC - Rp 8.300.6.10 NMAC, 7/1/2024]

HISTORY OF 8.300.6 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
SP-001.0400, Section 1, Single State Agency Organization State Medical Care Advisory Committee, filed 1/15/1981.
SP-004.0700, Section 4, General Program Administration Maintenance of Reports, filed 1/23/1981.
SP-001.0203, Section 1, Single State Agency Organization Professional Medical Personnel and Supporting Staff, filed 3/3/1981.
SP-004.0900, Section 4, General Program Administration Reporting Provider Payments to Internal Revenue Service, filed 3/3/1981.
SP-001.0202, Section 1, Single State Agency Organization and Function of Medical Assistance Unit, filed 3/11/1981.

History of Repealed Material:
8 NMAC 4.MAD.020, Responsibility and Delegation of Authority, filed 1/18/1995 - Repealed effective 4/15/2009.
8.300.6 NMAC - Responsibility And Delegation Of Authority (filed 3/25/2009) Repealed effective 7/1/2024.

Other: 8.300.6 NMAC - Responsibility And Delegation Of Authority (filed 3/25/2009) Replaced by 8.300.6 NMAC - Responsibility And Delegation Of Authority (filed 3/25/2009) Replaced by 8.300.6 NMAC - Responsibility And Delegation Of Authority effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 300 MEDICAID GENERAL INFORMATION
PART 11 CONFIDENTIALITY

8.300.11.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.300.11.1 NMAC - Rp 8.300.11.1 NMAC, 7/1/2024]

8.300.11.2 SCOPE: The rule applies to the general public.
[8.300.11.2 NMAC - Rp 8.300.11.2 NMAC, 7/1/2024]

8.300.11.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended and by state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.300.11.3 NMAC - Rp 8.300.11.3 NMAC, 7/1/2024]

8.300.11.4 DURATION: Permanent.
[8.300.11.4 NMAC - Rp 8.300.11.4 NMAC, 7/1/2024]

8.300.11.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.300.11.5 NMAC - Rp 8.300.11.5 NMAC, 7/1/2024]

8.300.11.6 OBJECTIVE: The objective of these rules is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.300.11.6 NMAC - Rp 8.300.11.6 NMAC, 7/1/2024]

8.300.11.7 DEFINITIONS: [**RESERVED**]

8.300.11.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.
[8.300.11.8 NMAC - Rp 8.300.11.8 NMAC, 7/1/2024]

8.300.11.9 CONFIDENTIALITY: The following applicant and eligible recipient information is confidential and is safeguarded by the HCA, all state agencies, their contractors and other authorized agents and all providers of MAD services. See 42 CFR 431.305(b) and 45 CFR 164.530(c):

A. name, address and social security number;

B. medical services furnished to the applicant and eligible recipient;

C. social and economic conditions or circumstances;

D. agency evaluation of personal information;

E. medical data, including diagnosis and past history of disease or disability;

F. information received to verify income eligibility and the amount of medical payments, including information received from the social security administration and the internal revenue service;

G. information received in connection with the identification of legally liable third parties;

H. telephone numbers;

I. fax numbers;

J. electronic mail addresses;

K. medical record numbers;

L. health plan beneficiary numbers;

M. account numbers; and

N. certificate/license numbers.

[8.300.11.9 NMAC - Rp 8.300.11.9 NMAC, 7/1/2024]

8.300.11.10 CONFIDENTIALITY OF APPLICANT/RECIPIENT INFORMATION:

A. Safeguarding of confidential applicant and eligible recipient information includes the methods of receiving, maintaining, and communicating individually identifiable health information. See 45 CFR Section 164.530(c).

B. Confidentiality of medical information: Confidential information regarding applicants or eligible recipients will be available to those identified in 8.300.11.9 NMAC for use only in connection with the administration of the New Mexico medical assistance programs and only on a need-to-know basis. See 42 CFR Section 431.300-307. Those using confidential information will only use the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. See 45 CFR Section 164.502(b).

C. Use of confidential medical information: The following individuals have access to medical information: employees of private firms, other divisions within HCA or other state agencies who are performing work or providing services for MAD under contract or business associate agreement or who are providing services, as required by federal law; employees or agents of the federal department of health and human services; and providers of health care services to eligible recipients.
[8.300.11.10 NMAC - Rp 8.300.11.10 NMAC, 7/1/2024]

8.300.11.11 CONFIDENTIALITY OF ELECTRONIC DATA:

A. Electronic transmission/reception of confidential information: To ensure that the confidential medical information of eligible recipients and applicants is kept confidential, transmission and reception of this information is limited to those individuals allowed to have access to medical information as stated in the use of confidential medical information policy (Paragraph (1) of Subsection B of 8.300.11.10 NMAC) and safeguarding protected health information policy 8.300.2.22 NMAC).

B. Provider participation: Providers who choose to send or receive confidential medical information via fax must have a dedicated fax line or fax machine. Confidential medical information should not be received at a commercial fax center where employees or customers may have access to the information. Providers who choose to send or receive confidential medical information via fax or email must follow the minimum necessary standard. See 45 CFR Section 164.502.

C. Responsibility for failure to follow rule: Providers who fail to adhere to this rule are solely liable for any consequences resulting from the use of this method of transmitting confidential medical information, including any attorney fees, costs or damages. MAD shall mitigate any harmful effect from improper disclosure of individually identifiable health information in accordance with 45 CFR Section 164.530(f).
[8.300.11.11 NMAC - Rp 8.300.11.11 NMAC, 7/1/2024]

HISTORY OF 8.300.11 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 327.0000, Confidentiality of Information, filed 5/8/1980.

SP-004.0300, Section 4, General Program Administration Safeguarding Information on Applicants and Recipients, filed 1/23/1981.

History of Repealed Material:
8 NMAC 4.MAD.034.2, Electronic Data Transfer of Medical Records - Repealed 5/31/1997.
8 NMAC 4.MAD.034.21, Notice Prior to Transmission - Repealed 5/31/1997.
8 NMAC 4.MAD.034.22, Responsibility for Failure to Follow Policy - Repealed 5/31/1997.
8.300.11 NMAC - Conflict of Interest (filed 6/16/2003) Repealed effective 7/1/2024.

Other: 8.300.11 NMAC - Conflict of Interest (filed 6/16/2003) Replaced by 8.300.11 NMAC - Conflict of Interest effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 300 MEDICAID GENERAL INFORMATION
PART 17 CONFLICT OF INTEREST

8.300.17.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.300.17.1 NMAC - Rp 8.300.17.1 NMAC, 7/1/2024]

8.300.17.2 SCOPE: The rule applies to the general public.
[8.300.17.2 NMAC - Rp 8.300.17.2 NMAC, 7/1/2024]

8.300.17.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.300.17.3 NMAC - Rp 8.300.17.3 NMAC, 7/1/2024]

8.300.17.4 DURATION: Permanent.
[8.300.17.4 NMAC - Rp 8.300.17.4 NMAC, 7/1/2024]

8.300.17.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.300.17.5 NMAC - Rp 8.300.17.5 NMAC, 7/1/2024]

8.300.17.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.300.17.6 NMAC - Rp 8.300.17.6 NMAC, 7/1/2024]

8.300.17.7 DEFINITIONS: [**RESERVED**]

8.300.17.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.300.17.8 NMAC - Rp 8.300.17.8 NMAC, 7/1/2024]

8.300.17.9 CONFLICT OF INTEREST: To prevent any former employee of the medical assistance division (MAD) from using privileged information or asserting improper influence, statutory provisions have been adopted. See Section 10-16-16 NMSA 1978 (Repl. Pamp. 1991):

A. An employee with "responsibility" must not act as agent or attorney for any other person or business in connection with a judicial or administrative proceeding, application, ruling, contract, claim or other matter relative to the medicaid program for 24 months following the date on which they cease to be an employee.

(1) Employee with "responsibility" refers to an employee who is directly involved in or has a significant part in the medicaid decision-making, regulatory, procurement or contracting process.

(2) This provision applies to employees with responsibility for investigating, making rulings or otherwise being substantially or directly involved with activities during their last year of employment with the agency.

(3) This provision also applies to activities which were actually pending and under the employee's responsibility within that period.

B. The secretary of the HCA (secretary), income support division director, administrative services division or medical assistance director or their deputies must not participate in any judicial or administrative proceeding, application, ruling, contract, claim or other matter relating to medicaid and pending before MAD for 12 months following the date they cease to be an employee.

C. An employee with responsibility must not participate in any judicial or administrative proceeding, application, ruling, contract, claim or other matter relating to medicaid which involves their spouse, minor child or any business in which they have financial interest, unless prior to each participation:

(1) the employee fully discloses the relationship or financial interest in writing to the secretary; and

(2) a written determination is made by the secretary that the disclosed employee relationship or financial interest is too remote or inconsequential to affect the integrity of the employee's services.
[8.300.17.9 NMAC - Rp 8.300.17.9 NMAC, 7/1/2024]

8.300.17.10 PENALTIES: Violation of any of the above provisions by an employee is

grounds for dismissal, demotion or suspension. A former employee who violates any of the provisions is subject to assessment by the HCA of a civil monetary penalty of $250 for each violation. MAD shall mitigate any harmful effect from improper disclosure of individually identifiable health information in accordance with 45 CFR Section 164.530(f). Any employee or former employee who violates these provisions may also be subject to criminal prosecution. See Section 10-16-17 NMSA 1978 (Cum. Supp. 1993).
[8.300.17.10 NMAC - Rp 8.300.17.10 NMAC, 7/1/2024]

8.300.17.11 APPEAL PROCESS: A request for appeal from the imposition of an administrative sanction must be made to the secretary within 30 days of the date on the written notification of a penalty assessment. Unless a proper request is received by the secretary within the 30 day limit, the HCA findings are considered a final and binding administrative determination.
[8.300.17.11 NMAC - Rp 8.300.17.11 NMAC, 7/1/2024]

HISTORY OF 8.300.17 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 301.2000, Provider Agreement, filed 12/21/1979.
ISD 301.2000, Provider Agreement, filed 12/4/1980.
MAD Rule 301, Procedures and Requirements for Provider Participation, filed 11/8/1989.
SP-004.2900, Section 4, General Program Administration Conflict of Interest Provisions, filed 3/5/1981.
ISD 301.3000, Confidentiality, filed 12/21/1979.
ISD 301.4000, Public Disclosure of Information, filed 1/7/1980.
ISD 301.4000, Public Disclosure of Information, filed 11/24/1980.

History of Repealed Material:
MAD Rule 301, Procedures and Requirements for Provider Participation, filed 11/8/1989 - Repealed effective 2/1/1995.
8.300.17 NMAC - Conflict Of Interest (filed 6/16/2003) Repealed effective 7/1/2024.

Other: 8.300.17 NMAC - Conflict Of Interest (filed 6/16/2003) Replaced by 8.300.17 NMAC - Conflict Of Interest effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 300 MEDICAID GENERAL INFORMATION
PART 21 MEDICAL ASSISTANCE DIVISION POLICY MANUAL

8.300.21.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.300.21.1 NMAC - Rp 8.300.21.1 NMAC, 7/1/2024]

8.300.21.2 SCOPE: The rule applies to the general public.
[8.300.21.2 NMAC - Rp 8.300.21.2 NMAC, 7/1/2024]

8.300.21.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended, or by state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 2007). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.300.21.3 NMAC - Rp 8.300.21.3 NMAC, 7/1/2024]

8.300.21.4 DURATION: Permanent.
[8.300.21.4 NMAC - Rp 8.300.21.4 NMAC, 7/1/2024]

8.300.21.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.300.21.5 NMAC - Rp 8.300.21.5 NMAC, 7/1/2024]

8.300.21.6 OBJECTIVE: The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs.
[8.300.21.6 NMAC - Rp 8.300.21.6 NMAC, 7/1/2024]

8.300.21.7 DEFINITIONS: [**RESERVED**]

8.300.21.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.
[8.300.21.8 NMAC - Rp 8.300.21.8 NMAC, 7/1/2024]

8.300.21.9 MEDICAL ASSISTANCE DIVISION POLICY MANUAL: The MAD rule manual (the manual) contains detailed information about the New Mexico medical assistance programs. It is intended for use by all participating providers who furnish health services, MAD applicants/recipients, HCA employees and designees, contractors, and all other interested parties.

A. Purpose of the manual: The purpose of the manual is to provide an overview of general rules on the administration and financing of medicaid and other health care programs administered by MAD, recipient eligibility, coverage of services, and reimbursement by provider group. Once enrolled, MAD providers receive instructions on how to access instructions, and other pertinent materials. The MAD eligibility manual sections are available at the HCA website or other program specific websites.

B. Updating manual: To ensure that MAD rules contained in this manual remains current,

providers, local county ISD offices, and other interested parties on the mailing list are notified of updates at the conclusion of the publication process. The finalized rules are available on the HCA website or other program specific websites for viewing and copying.

(1) Rule updates are distributed in the form of New Mexico medical assistance manual revisions (MAD-MR). Each MAD-MR provides the rationale for the rule revision, specific changes, and instructions for updating the affected manual sections.

(2) Updates for claims processing, prior authorization, and utilization review instructions for providers are distributed in the form of MAD supplements.

[8.300.21.9 NMAC - Rp 8.300.21.9 NMAC, 7/1/2024]

HISTORY OF 8.300.21 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
SP-004.0800, Section 4, General Program Administration Availability of Agency Program Manuals, filed 1/23/1981.

History of Repealed Material:
8 NMAC 4.MAD.080, Medical Assistance Division Policy Manual, filed 1/18/1995 - Repealed effective 4/15/2009.
8.300.21 NMAC - Medical Assistance Division Policy Manual (filed 3/25/2009) Repealed effective 7/1/2024.

Other: 8.300.21 NMAC - Medical Assistance Division Policy Manual (filed 3/25/2009) Replaced by 8.300.21 NMAC - Medical Assistance Division Policy Manual effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 301 MEDICAID GENERAL BENEFIT DESCRIPTION
PART 5 MEDICAL MANAGEMENT

8.301.5.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.301.5.1 NMAC - Rp 8.301.5.1 NMAC, 7/1/2024]

8.301.5.2 SCOPE: The rule applies to the general public.
[8.301.5.2 NMAC - Rp 8.301.5.2 NMAC, 7/1/2024]

8.301.5.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.301.5.3 NMAC - Rp 8.301.5.3 NMAC, 7/1/2024]

8.301.5.4 DURATION: Permanent.
[8.301.5.4 NMAC - Rp 8.301.5.4 NMAC, 7/1/2024]

8.301.5.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.301.5.5 NMAC - Rp 8.301.5.5 NMAC, 7/1/2024]

8.301.5.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.301.5.6 NMAC - Rp 8.301.5.6 NMAC, 7/1/2024]

8.301.5.7 DEFINITIONS: [**RESERVED**]

8.301.5.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.301.5.8 NMAC - Rp 8.301.5.8 NMAC, 7/1/2024]

8.301.5.9 MEDICAL MANAGEMENT: The New Mexico medicaid program (medicaid) pays for medically necessary medical services furnished to medicaid recipients. To make sure that recipients receive only necessary services, the New Mexico medical assistance division (MAD) has developed the medical management program. The medical management program is designed to enhance the receipt of health care to a recipient by assigning a designated provider. This may also reduce the use of unnecessary services by medicaid recipients in certain instances. See 42 CFR 431.54(e). Medical management involves the identification of appropriate cases, selection of actual cases, documentation of the health care issue(s) necessitating management, development of assignment recommendations, and evaluation of the effectiveness of the assignments. The medical assistance division (MAD) medical director or another physician specifically appointed by MAD determines whether recipients are assigned to the medical management program.
[8.301.5.9 NMAC - Rp 8.301.5.9 NMAC, 7/1/2024]

8.301.5.10 SERVICES EXCLUDED FROM MEDICAL MANAGEMENT: Recipients can receive emergency services and inpatient services without referrals

from their designated providers. These services are exempt from medical management. Emergency room claims for services provided to any recipient may be reviewed before or after payment. Inappropriate non-emergency use of emergency room services results in denial of payment by medicaid and liability of the recipient for payment.
[8.301.5.10 NMAC - Rp 8.301.5.10 NMAC, 7/1/2024]

8.301.5.11 IDENTIFICATION OF CANDIDATES: All medicaid recipients are potential candidates for inclusion in medical management, whether enrolled in Salud! or covered under medicaid fee-for-service. Recipients are identified as candidates for review by HCA, the MCO, a provider or other appropriate entities. The following situations may indicate a need for medical management:

A. individuals who overutilize medical services;

B. individuals who are habitually non-compliant and miss appointments, or who frequently seek unauthorized treatment or care; and

C. individuals who frequently change PCPs or simultaneously utilize multiple pharmacy providers;

D. individuals who regularly utilize emergency room services for inappropriate, non-emergency care.
[8.301.5.11 NMAC - Rp 8.301.5.11 NMAC, 7/1/2024]

8.301.5.12 SELECTION FOR MEDICAL MANAGEMENT: HCA staff analyzes appropriate reports and documentation to decide whether a recipient will be referred to the MAD medical director for medical management determination. After reviewing HCA staff recommendations and supporting documentation, the MAD medical director or another physician designated by MAD determines whether the recipient should be assigned to medical management. Once the determination is made by the physician, the assignment of the recipient to medical management is implemented by MAD. The assignment is subject to the notice requirements and hearing process described below in Section 15, *Recipient Notice* and Section 16, *Recipient Hearings*.

A. Notification of decision: The HCA staff notifies the recipient, the claims processing contractor, the income support division (ISD), and, if enrolled in Salud!, the MCO, of the medical management assignments. Providers are informed that a client is in medical management at the time the provider verifies the client's eligibility for the date the services are provided. Recipients placed in medical management receive medicaid identification cards which indicate "medical management" and the names of their "designated providers".

B. Assignments for recipients covered by third party insurers: Recipients who are eligible for medicare and medicaid services or recipients who have insurance can be assigned to a designated provider for services covered exclusively by medicaid. Recipients in managed care plans are assigned to designated providers who participate in the recipient's plan.
[8.301.5.12 NMAC - Rp 8.301.5.12 NMAC, 7/1/2024]

8.301.5.13 DESIGNATED PROVIDERS: Recipients who are in medical management are assigned to designated providers based on their specific health care situation. Recipients may be assigned to a designated provider who manages the recipient's overall receipt of health services by making referrals, a designated provider who furnishes only specialty services, or both. Medicaid payment for medical services is restricted to designated providers. Other providers can receive payment for services furnished to a recipient in medical management only with a referral from the designated provider. If a recipient is assigned a designated psychiatrist, only that psychiatrist is reimbursed by medicaid or the MCO for providing outpatient psychiatric services to the recipient, unless the designated psychiatrist determines that it is medically necessary for the recipient to be referred to a second psychiatrist. If a recipient is assigned a designated general provider, only that provider is reimbursed by medicaid or the MCO for providing outpatient services to the recipient, unless the designated general provider determines that it is medically necessary for the recipient to be referred to a secondary provider. If a recipient is assigned a designated pharmacy provider, only that provider is reimbursed by medicaid fee-for-service or the MCO.

A. Selection of designated providers: Providers of outpatient services are selected as "designated providers". The following guidelines are used to select a provider:

(1) the provider must be a medicaid fee-for-service or MCO contracted provider;

(2) the provider agrees to act in the capacity of a designated provider;

(3) the geographic location of the provider must not significantly impair or impede the recipient's access to services; and

(4) when feasible, the provider is one with whom the recipient has previously established a medically-beneficial relationship;

(5) if the designated provider is not the recipient's PCP, then the provider must coordinate with the recipient's PCP.

B. Changing designated providers: When any of the following circumstances occur, the MAD medical director or another physician designated by MAD can approve a request to change the designated providers permanently:

(1) the recipient moves from the geographic area of the designated provider;

(2) the recipient's medical condition changes and the designated provider is unable to furnish care or refer the recipient to an appropriate provider;

(3) the designated provider is no longer available or gives notice that they are no longer willing to serve as a designated provider; or

(4) the designated provider no longer participates in the medicaid program.
[8.301.5.13 NMAC - Rp 8.301.5.13 NMAC, 7/1/2024]

8.301.5.14 REEVALUATION OF ASSIGNMENT: Initial medical management assignments are reevaluated by the HCA staff within a year of the effective date of the assignment or from the date of reevaluation. The reevaluation focuses on whether assignments met the objectives identified in the HCA staff recommendation or whether the initial assignments need modification. A reevaluation is conducted using information similar to that used in the initial medical management assignment analysis. If continuation or modification of an assignment is necessary, the reasons for the action are documented in the case file. The MAD medical director or another physician designated by MAD makes the final decision as to whether the assignment needs to be continued, modified or removed.

A. Medicaid eligibility changes: Changes in recipient eligibility status do not affect the status of a recipient in medical management or the reevaluation process. If a recipient on medical management becomes ineligible for medicaid benefits but later becomes medicaid eligible within the assignment period, the recipient remains in medical management.

B. Removal from the medical management program: Recipients are removed from medical management by HCA staff when the specific situation necessitating medical management has been resolved.
[8.301.5.14 NMAC - Rp 8.301.5.14 NMAC, 7/1/2024]

8.301.5.15 RECIPIENT NOTICE: The medical assistance division gives a recipient and the MCO, if the recipient is enrolled in Salud!, 13 working days notice of the decision to place the recipient in medical management. Notice is given for the initial imposition of the assignment, modification of the assignment, or continuation of the assignment.

A. Time constraints: A recipient can submit a request for a hearing of their assignment into medical management, assignment of the designated providers, modification, or continuation of the assignment. If the recipient requests a hearing within the time frame established below in Section 16, *Recipient Hearing*, the proposed assignment shall remain imposed until a hearing decision states otherwise.

B. Information contained in the notice: The recipient notice contains the following information 42 CFR 431.210:

(1) statement describing the action MAD intends to take;

(2) reasons for the intended action;

(3) specific state or federal regulations supporting the action or change(s) in the law which require the action;

(4) explanation of the recipient's right to request an administrative hearing and the method and timetable by which the hearing can be requested;

(5) statement explaining the recipient's right to be represented at the administrative hearing by legal counsel, a friend, or other representative;

(6) explanation of the circumstances under which the benefits are continued; and

(7) effective date of the assignment.
[8.301.5.15 NMAC - Rp 8.301.5.15 NMAC, 7/1/2024]

8.301.5.16 RECIPIENT HEARING: A recipient has a right to request a hearing regarding the MAD decision to assign the recipient into medical management. The request must be submitted to the quality assurance bureau of MAD, the HCA hearing bureau or the local ISD office within 90 days of the date the notice of action was postmarked. See 8.352.2 NMAC, *Recipient Hearings*.
[8.301.5.16 NMAC - Rp 8.301.5.16 NMAC, 7/1/2024]

HISTORY OF 8.301.5 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:
ISD 325.0000, Medical Care Management, 5/6/1980.
ISD-Rule 325.0000, Medical Care Management, 1/29/1986.
MAD Rule 325.00, Medical Care Management, 3/14/1994.
SP-004.1400, Section 4, General Program Administration Utilization Control, 3/3/1981.

History of Repealed Material:
MAD Rule 325.00, Medical Management Program, Repealed, 1/8/1995.
8.301.5 NMAC - Medical Management (filed 6/14/2001) Repealed effective 7/1/2024.

Other: 8.301.5 NMAC - Medical Management (filed 6/14/2001) Replaced by 8.301.5 NMAC - Medical Management effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 301 MEDICAID GENERAL BENEFIT DESCRIPTION
PART 6 CLIENT MEDICAL TRANSPORTATION SERVICES

8.301.6.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.301.6.1 NMAC - Rp 8.301.6.1 NMAC, 7/1/2024]

8.301.6.2 SCOPE: The rule applies to the general public.

[8.301.6.2 NMAC - Rp 8.301.6.2 NMAC, 7/1/2024]

8.301.6.3 STATUTORY AUTHORITY: The New Mexico medicaid and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under the Social Security Act as amended, or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.301.6.3 NMAC - Rp 8.301.6.3 NMAC, 7/1/2024]

8.301.6.4 DURATION: Permanent.
[8.301.6.4 NMAC - Rp 8.301.6.4 NMAC, 7/1/2024]

8.301.6.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.301.6.5 NMAC - Rp 8.301.6.5 NMAC, 7/1/2024]

8.301.6.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs.
[8.301.6.6 NMAC - Rp 8.301.6.6 NMAC, 7/1/2024]

8.301.6.7 DEFINITIONS: [**RESERVED**]

8.301.6.8 MISSION STATEMENT: To reduce the impact of poverty on the people living in New Mexico and to assure low income and individuals with disabilities in New Mexico equal participation in the life of their communities.
[8.301.6.8 NMAC - Rp 8.301.6.8 NMAC, 7/1/2024]

8.301.6.9 CLIENT MEDICAL TRANSPORTATION SERVICES: The medical assistance division (MAD) covers expenses for transportation, meals and lodging it determines are necessary to secure MAD covered medical examination and treatment for eligible recipients in or out of their home community 42 CFR 440.170. Travel expenses include the cost of transportation by long distance common carrier, taxicab, handivan, and ground or air ambulance, all as appropriate to the situation and location of the eligible recipient. When medically necessary, MAD covers similar expenses for an attendant who accompanies the eligible recipient to the medical examination or treatment.
[8.301.6.9 NMAC - Rp 8.301.6.9 NMAC, 7/1/2024]

8.301.6.10 COVERED SERVICES AND SERVICE LIMITATIONS: MAD reimburses eligible recipients or transportation providers for medically necessary transportation subject to the following:

A. Free alternatives: Alternative transportation services which may be provided free of charge, include volunteers, relatives or transportation services provided by nursing facilities or other residential centers. An eligible recipient must certify in writing that they do not have access to free alternatives.

B. Least costly alternatives: MAD covers the most appropriate and least costly transportation alternatives suitable for the eligible recipient's medical condition. If an eligible recipient can use private vehicles or public transportation, those alternatives must be used before the eligible recipient can use more expensive transportation alternatives.

C. Non-emergency transportation service: MAD covers non-emergency transportation services for an eligible recipient who does not have primary transportation and who is unable to access a less costly form of public transportation.

D. Long distance common carriers: MAD covers long distance services furnished by a common carrier if the eligible recipient must leave their home community to receive medical services. Authorization forms for direct payment to long distance bus common carriers by MAD are available through the eligible recipient's local county income support division (ISD) office.

E. Ground ambulance services: MAD covers services provided by ground ambulances when:

(1) an emergency which requires ambulance service is certified by a physician or is documented in the provider's records as meeting emergency medical necessity as defined as:

(a) an emergency condition that 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; and

(b) "medical necessity" for ambulance services is established if the eligible recipient's condition is such that the use of any other method of transportation is contraindicated and would endanger the eligible recipient's health;

(2) scheduled, non-emergency ambulance services are ordered by a physician who certifies that the use of any other method of non-emergency transportation is contraindicated by the eligible recipient's medical condition; and

(3) MAD covers non-reusable items and oxygen required during transportation; coverage for these items are included in the base rate reimbursement for ground ambulance.

F. Air ambulance services: MAD covers services provided by air ambulances, including private airplanes, if an emergency exists and the medical necessity for the service is certified by the physician.

(1) 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) MAD covers the following services for air ambulances:

(a) non-reusable items and oxygen required during transportation;

(b) professional attendants required during transportation; and

(c) detention time or standby time up to one hour without physician documentation; if the detention or standby time is more than one hour, a statement from the attending physician or flight nurse justifying the additional time is required.

G. Lodging services: MAD covers lodging services if recipients are required to travel to receive medical services more than four hours one way and an overnight stay is required due to medical necessity or cost considerations. If medically justified and approved, lodging is initially set for up to five continuous days. For a longer stay, the need for lodging must be re-evaluated by the fifth day to authorize up to an additional 15 days. Re-evaluation must be made every 15 days for extended stays, prior to the expiration of the existing authorization. Approval of lodging is based on the medical provider's statement of need. Authorization forms for direct payment to medicaid lodging providers by MAD are available through local county income support division (ISD) offices.

H. Meal services: Medicaid covers meals if a recipient is required to leave their home community for eight hours or more to receive medical services. Authorization forms for direct payment to medicaid meal providers by MAD are available through local county ISD offices.

I. Coverage for attendants: MAD covers transportation, meals and lodging in the same manner as for an eligible recipient, for one attendant if the medical necessity for the attendant is certified in writing by the eligible recipient's medical provider or the eligible recipient who is receiving medical service is under 18 years of age. If the medical appointment is for an adult recipient, MAD does not cover transportation services or related expenses of children under 18 years of age traveling with the adult recipient.

J. Coverage for medicaid waiver recipients: Transportation of a medicaid waiver recipient to a provider of a waiver service is only covered when the service is occupational therapy, physical therapy, speech therapy and behavioral therapy services.

K. Medicaid family planning waiver eligible recipients: MAD does not cover transportation service for recipients eligible for medicaid family planning waiver services.

[8.301.6.10 NMAC - Rp 8.301.6.10 NMAC, 7/1/2024]

8.301.6.11 NONCOVERED SERVICES: Transportation services are subject to the same limitations and coverage restrictions which exist for other services. A payment for transportation to a MAD non-covered service is subject to retroactive recoupment. MAD does not cover the following services or related costs of travel:

A. attendants where there is not required certification from the eligible recipient's medical provider;

B. minor aged children of the eligible recipient that are simply accompanying the eligible recipient to medical services;

C. transportation to a non-covered MAD service;

D. transportation to a pharmacy provider. See Subsection F of 8.324.14.18 NMAC, *transportation services.* See 8.301.3 NMAC, *General Noncovered Services*.

[8.301.6.11 NMAC - Rp 8.301.6.11 NMAC, 7/1/2024]

8.301.6.12 OUT-OF-STATE TRANSPORTATION AND RELATED EXPENSES: All out-of-state transportation, meals and lodging must be prior approved by MAD. Out-of-state transportation is approved only if the out-of-state medical service is approved. Documentation must be available to the reviewer to justify the out-of-state travel and verify that treatment is not available in the state of New Mexico.

A. Requests for out-of-state transportation must be coordinated through the MAD client services bureau or MAD's designated contractor.

B. Authorization for lodging and meal services by out-of-state providers can be granted for up to 30 calendar days by MAD. Re-evaluation authorizations are completed prior to expiration and every 30 days, thereafter.

C. Transportation to border cities, those cities within 100 miles of the New Mexico border (Mexico excluded), are treated as in-state provider service. An eligible recipient who receives MAD reimbursable services from a border area provider is eligible for transportation services to that provider. See 8.302.4 NMAC, *Out of State and Border Area Providers,* to determine when a provider is considered an out-of-state provider or a border area provider.

[8.301.6.12 NMAC - Rp 8.301.6.12 NMAC, 7/1/2024]

8.301.6.13 CLIENT MEDICAL TRANSPORTATION FUND: In non-emergency situations, an eligible recipient can request reimbursement from the client medical transportation (CMT) fund through their local county ISD office for money they spend on transportation, meals and lodging. For reimbursement from the CMT fund, an eligible recipient must apply for reimbursement within 30-calendar days after the appointment.

A. Information requirements: The following information must be furnished to the ISD CMT fund custodian within 30-calendar days of the provider visit to receive reimbursement:

(1) submit a letter on the provider's stationary which indicates that the eligible recipient kept the appointment(s) for which the CMT fund reimbursement is requested; for medical services, written receipts confirming the dates of service must be given to the eligible recipient for submission to the local county ISD office;

(2) proper referral with original signatures and documentation stating that the services are not available within the community from the designated MAD medical management provider or MAD primary care provider, when a referral is necessary;

(3) verification of current eligibility for a MAD service for the month the appointment and travel are made;

(4) certification that free alternative transportation services are not available and that the recipient is not enrolled in a managed care organization;

(5) verification of mileage; and

(6) documentation justifying a medical attendant.

B. Fund advances in emergency situations: Money from the CMT fund is advanced for travel only if an emergency exists. "Emergency" is defined in this instance as a non-routine, unforeseen accident, injury or acute illness demanding immediate action and for which transportation arrangements could not be made five calendar days in advance of the visit to the provider. Advance funds must be requested and disbursed prior to the medical appointment.

(1) The ISD CMT fund custodian or a MAD fee-for-service coordinated service contractor or the appropriate utilization contractor verifies that the recipient is eligible for a MAD service and has a medical appointment prior to advancing money from the CMT fund and that the recipient is not enrolled in a managed care organization.

(2) Written referral for out of community service must be received by the CMT fund custodian or a MAD fee-for-service coordinated service contractor or the appropriate utilization contractor no later than 30-calendar days from the date of the medical appointment for which the advance funds were requested. If an eligible recipient fails to provide supporting documentation, recoupment proceedings are initiated. See Section OIG-900, Restitutions.
[8.301.6.13 NMAC - Rp 8.301.6.13 NMAC, 7/1/2024]

8.301.6.14 CMT REIMBURSEMENT RATES: Reimbursement for lodging and meal expenses is based on the MAD allowable fee schedule. The CMT fund reimbursement rate for transportation services and related expenses are:

A. private automobile use is reimbursed by the mile, based on the established MAD reimbursement schedule;

B. meals are reimbursed at the rate established by MAD; authorization forms used for direct payment to medicaid meal providers by MAD are available through the recipient's local county ISD office;

C. lodging is reimbursed at the rate established by MAD; authorization forms for direct payment to medicaid lodging providers by MAD are available through the recipient's local county ISD office; and

D. the CMT fund reimbursement rate for transportation services is at the established MAD reimbursement schedule per mile when a private automobile is used.
[8.301.6.14 NMAC - Rp 8.301.6.14 NMAC, 7/1/2024]

HISTORY OF 8.301.6 NMAC:
[**RESERVED**]

History of Repealed Material:
8.301.6 NMAC - Client Medical Transportation Services (filed 2/14/2011) Repealed effective 7/1/2024.

Other: 8.301.6 NMAC - Client Medical Transportation Services (filed 2/14/2011) Replaced by 8.301.6 NMAC - Client Medical Transportation Services effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 302 MEDICAID GENERAL PROVIDER POLICIES
PART 1 GENERAL PROVIDER POLICIES

8.302.1.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.302.1.1 NMAC - Rp, 8.302.1.1 NMAC, 7/1/2024]

8.302.1.2 SCOPE: The rule applies to the general public.
[8.302.1.2 NMAC - Rp, 8.302.1.2 NMAC, 7/1/2024]

8.302.1.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as

amended, and by state statute. See 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.302.1.3 NMAC - Rp, 8.302.1.3 NMAC, 7/1/2024]

8.302.1.4 DURATION: Permanent.
[8.302.1.4 NMAC - Rp, 8.302.1.4 NMAC, 7/1/2024]

8.302.1.5 EFFECTIVE DATE: July 1, 2024, unless a late date is cited at the end of a section.
[8.302.1.5 NMAC - Rp, 8.302.1.5 NMAC, 7/1/2024]

8.302.1.6 OBJECTIVE: The objective of these rules is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.302.1.6 NMAC - Rp, 8.302.1.6 NMAC, 7/1/2024]

8.302.1.7 DEFINITIONS:
Medically necessary services

A. Medically necessary services are clinical and rehabilitative physical or behavioral health services that:

(1) are essential to prevent, diagnose or treat medical conditions or are essential to enable an eligible recipient to attain, maintain or regain functional capacity;

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

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

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

B. Application of the definition:

(1) A determination that a service is medically necessary does not mean that the service is a covered benefit or an amendment, modification or expansion of a covered benefit, such a determination will be made by MAD or its designee.

(2) The HCA or its authorized agent making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the specific program's benefit package applicable to an eligible recipient shall do so by:

(a) evaluating the eligible recipient's physical and behavioral health information provided by qualified professionals who have personally evaluated the eligible recipient within their scope of practice, who have taken into consideration the eligible recipient'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;

(b) considering the views and choices of the eligible recipient or their personal representative regarding the proposed covered service as provided by the clinician or through independent verification of those views; and

(c) considering the services being provided concurrently by other service delivery systems.

(3) Physical and behavioral health services shall not be denied solely because the eligible recipient has a poor prognosis. Required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible recipient solely because of the diagnosis, type of illness or condition.

(4) Decisions regarding MAD benefit coverage for eligible recipients under 21 years of age shall be governed by the early periodic screening, diagnosis and treatment (EPSDT) coverage rules.

(5) Medically necessary service requirements apply to all medical assistance program rules.
[8.302.1.7 NMAC - Rp, 8.302.1.7 NMAC, 7/1/2024]

8.302.1.8 MISSION STATEMENT: To transform lives. Working with our partners, we design and deliver innovative, high-quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.302.1.8 NMAC - Rp, 8.302.1.8 NMAC, 7/1/2024]

8.302.1.9 GENERAL PROVIDER POLICIES: Medically necessary services are reimbursed by the MAD under Title XIX of the Social Security Act as amended, or by state statute.
[8.302.1.9 NMAC - Rp, 8.302.1.9 NMAC, 7/1/2024]

8.302.1.10 ELIGIBLE PROVIDERS:

A. Upon the approval of a New Mexico MAD provider participation agreement by MAD or its designee, a licensed practitioner or facility that meets applicable requirements is eligible to be reimbursed for furnishing covered services to an eligible program recipient. A provider must be enrolled before submitting a claim for payment to the appropriate MAD claims processing contractor. MAD makes available on the HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billings instructions, utilization review instructions, and other pertinent materials. When enrolled, providers receive instructions on how to access these documents. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided and to

comply with the requirements. The provider must contact HCA or its authorized agents to request hard copies of any program rules manuals, billing and utilization review instructions, and other pertinent materials and to obtain answers to questions on or not covered by these materials. To be eligible for reimbursement, a provider is bound by the provisions of the MAD provider participation agreement and all applicable statutes, regulations and executive orders.

B. When services are billed to and paid by a coordinated services contractor authorized by HCA, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

[8.302.1.10 NMAC - Rp, 8.302.1.10 NMAC, 7/1/2024]

8.302.1.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS: A provider who furnishes services to a medicaid eligible recipient agrees to comply with all federal and state laws, regulations, and executive orders relevant to the provision of services. A provider also must conform to MAD program rules, instructions, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services. A provider must verify that individuals are eligible for a specific health care program administered by the HCA and its authorized agents and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

A. Eligibility determination: A provider must verify recipient eligibility prior to providing services and verify that the recipient remains eligible throughout periods of continued or extended services.

(1) A provider may verify eligibility through several mechanisms, including using the automated voice response system, contacting MAD or designated contractor eligibility help desks, contracting with an eligibility verification system vendor, or by using the New Mexico medicaid portal.

(2) An eligible recipient becomes financially responsible for a provider claim if the eligible recipient:

(a) fails to identify themselves as a MAD eligible recipient; or

(b) fails to state that an eligibility determination is pending; or

(c) fails to furnish MAD identification before the service is rendered and MAD denies payment because of the resulting inability of the provider to be able to file a claim timely; or

(d) receives services from a provider that lacks MAD enrollment, is not eligible to provide the services or does not participate in MAD programs.

B. Requirements for updating information: A provider must furnish MAD or the appropriate MAD claims processing contractor with complete information on changes in their address, license, certification, board specialties, corporate name or corporate ownership, and a statement as to the continuing liability of the provider for any recoverable obligation to MAD which occurred or may have occurred prior to any sale, merger, consolidation, dissolution or other disposition of the provider or person. MAD or the appropriate MAD claims processing contractor must receive this information at least 60 calendar days before the change. Any payment made by MAD based upon erroneous or outdated information is subject to recoupment or provider repayment. The provider must provide MAD with information, in writing, updating their provider participation agreement of any conviction of delineated criminal or civil offenses against the provider or parties with direct or indirect ownership or controlling interest within 10 calendar days after the conviction.

C. Additional requirements: A provider must meet all other requirements stated in the program rules, billing instructions, manual revisions, supplements, and signed application forms or re-verification forms, as updated. MAD may require a letter of credit, a surety bond, or a combination thereof, from the provider. The letter of credit, surety bond or combination thereof may be required if any one of the following conditions is met:

(1) the provider is the subject of a state or federal sanction or of a criminal, civil, or departmental proceeding in any state;

(2) a letter of credit, surety bond, or any combination thereof is required for each provider of a designated provider type;

(3) the provider cannot reasonably demonstrate that they have assumed liability and are responsible for paying the amount of any outstanding recoveries to MAD as the result of any sale, merger, consolidation, dissolution, or other disposition of the provider or person; or

(4) the secretary determines that it is in the best interest of MAD to do so, specifying the reasons.

[8.302.1.11 NMAC - Rp, 8.302.1.11 NMAC, 7/1/2024]

8.302.1.12 ELIGIBLE MEDICAID RECIPIENTS: To comply with Title XIX of the Social Security Act, as amended, MAD is required to serve certain groups of eligible recipients and has the option of paying for services provided to other eligible recipient groups 42 CFR 435.1. MAD is also required to pay for emergency services furnished to non-citizens residing in New Mexico who are not lawfully admitted for permanent residence but

who otherwise meet the eligibility requirements. Coverage is restricted to those services necessary to treat an emergency medical condition, which includes labor and delivery services. See 8.325.10.3 NMAC.

A. Recipient eligibility determination: To be eligible to receive MAD benefits, an applicant/recipient must meet general eligibility or resource and income requirements. These requirements vary by category of eligibility and may vary between health care programs. See 8.200 NMAC for information on medicaid eligibility requirements.

(1) An otherwise eligible recipient who is under the jurisdiction or control of the correctional system or resides in a public institution is not eligible for medicaid.

(2) MAD eligibility determinations are made by the following agencies:

(a) the staff of the income support division (ISD) county offices determines eligibility for medicaid categories of eligibility;

(b) the staff of the New Mexico children, youth and families department (CYFD) determines eligibility for child protective services, adoptive services and foster care children;

(c) the staff of the social security administration determines eligibility for social security income (SSI); and

(d) the staff of a federally qualified health center, a maternal and child health services block grant program, the Indian health service, and other designated agents make presumptive eligibility determinations.

B. Recipient freedom of choice: Unless otherwise restricted by specific health care program rules, an eligible recipient has the freedom of choice to obtain services from in-state and border providers who meet the requirements for MAD provider participation. Some restrictions to this freedom of choice apply to an eligible recipient who is assigned to a provider or providers in the medical management program (45 CFR 431.54 (e)). See 301.5 NMAC, *Medical Management.* Some restrictions to this freedom of choice may also apply to purchases of medical devices, and laboratory and radiology tests and other services and items as allowed by federal law (42 CFR 431.54 (d)).

C. Recipient identification: An eligible recipient must present all health program identification cards or other eligibility documentation before receiving services and with each case of continued or extended services.

(1) A provider must verify the eligibility of the recipient to assure the recipient is eligible on the date the services are provided. Verification of eligibility also permits the provider to be informed of any restrictions or limitations on services associated with the recipient's eligibility; of the applicability of co-payments on services; of the need for the eligible recipient's care to be coordinated with or provided through a managed care organization, a hospice provider, a PACE provider, a medical management provider, or similar health care plan or provider. Additionally, information on medicare eligibility and other insurance coverage may be provided.

(2) An eligible recipient whose health care program coverage or benefits may be limited include:

(a) qualified medicare beneficiary (QMB) recipient; and

(b) family planning benefits.

[8.302.1.12 NMAC - Rp, 8.302.1.12 NMAC, 7/1/2024]

8.302.1.13 PATIENT SELF DETERMINATION ACT: A hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, hospice agency and home health agency is required to give an eligible recipient or personal representative information about their right to make their own health decisions, including the right to accept or refuse medical treatment, pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1990. An eligible recipient is not required by this legislation to execute advance directives. Advance directives, such as living wills or durable power of attorney documents, must be established in a manner which is recognized under New Mexico state law. See applicable state law. A health care provider cannot object on the basis of conscience when an eligible recipient or personal representative wishes to implement an advance directive.

A. Information requirements: At the time of admission, a provider is required to provide written information to an adult eligible recipient or personal representative concerning their right to do the following:

(1) make decisions about their medical care;

(2) accept or refuse medical or surgical treatment;

(3) execute advance directives;

(4) execute their rights under HIPAA; and

(5) if an eligible recipient who is already incapacitated is admitted, the provider must provide their personal representatives with this information; if an eligible recipient is no longer incapacitated, the provider must discuss these rights with the eligible recipient.

B. Policies, rules and procedures: A provider must give written information to an eligible adult recipient or their personal representative about provider rules and procedures concerning advance directive rights. A provider must verify that the advance directive complies with state law.

C. Documentation requirements: A provider must document in each eligible recipient's medical record whether their personal representative has established an advance directive. If the eligible recipient or their personal representative presents an advanced directive, a provider must comply

with the terms of the document, as directed by state law. If an eligible recipient is incapacitated, unable to communicate, or their personal representative does not present an advance directive, the provider must document that the eligible recipient was unable to receive information or communicate whether advance directives exist. A provider must inform the eligible recipient or their personal representative that it furnishes information and proper forms for completion of advance directives.

D. Provision of care: A provider must not condition the provision of care or discriminate against an eligible recipient based on whether they have established advance directives. If an eligible recipient is entitled to necessary care ordered by a physician, which providers under normal procedures must furnish, care cannot be delayed while waiting for the execution of an advance directive. Once the existence of an advance directive is documented, the directive takes precedence over normal procedures.

E. Changing the advanced directives: A provider must inform an eligible recipient or their personal representative that they have a right to reaffirm an advance directive or change an advance directive at any time and in any manner, including oral statements.

[8.302.1.13 NMAC - Rp, 8.302.1.13 NMAC, 7/1/2024]

8.302.1.14 NONDISCRIMINATION: A provider must furnish covered services to an eligible recipient in the same scope, quality and manner as provided to the general public. Within the limits of medical assistance programs, a provider may not discriminate on the basis of race, color, national origin, sex, gender, age, ethnicity, religion, sexual orientation, sexual preference, health status, disability, marital status, political belief, or source of payment, (45 CFR 80.3 (a)(b); 45 CFR 84.52 (a); 42 CFR 447.20; and PL 101-366, 104 Stat. 327 (1990)).

[8.302.1.14 NMAC - Rp, 8.302.1.14 NMAC, 7/1/2024]

8.302.1.15 BILLING AND CLAIMS PROCESSING: Reimbursement to a provider for services or procedures is based on the MAD reimbursement fee schedule, reimbursement rate, or reimbursement methodology in place at the time the services were furnished by the provider. A provider who furnishes services to an eligible recipient agrees to accept the amount paid by MAD as payment in full, except as otherwise allowed by rule or regulation (42 CFR 447.15).

A. Requirements for reimbursement: A provider is reimbursed for performing a service or procedure only if any required prior authorization, documentation, certifications, or acknowledgements are submitted with the claim and the claim is received by the appropriate claims processing contractor within the filing limits.

B. Electronic billing requirements: Effective December 1, 2008, electronic billing of claims is mandatory unless an exemption has been allowed by MAD. Electronic billing improves the accuracy of claims submission and payment; provides consistency in billing information; and improves the speed of payment. Exemptions will be given on a case by case basis with consideration given to barriers the provider may face in billing electronically, including when volumes are so small that developing electronic submission capability is impractical. The requirement for electronic submission of claims does not apply to situations for which paper attachments must accompany the claim form.

C. Responsibility for claims: A provider is responsible for all claims submitted under their national provider identifier (NPI) or other provider number including responsibility for accurate coding that represents the services provided without inappropriately upcoding, unbundling, or billing mutually exclusive codes as indicated by published coding manuals, directives, and the CMS correct coding initiative.

D. No billing of recipients or third parties: With the exception of WDI and SCHIP or other specified program co-payments or cost-sharing, a provider may not bill, turn over to collection, or accept payment from an eligible recipient, their personal representative or other third parties determined to be legally responsible for the balance of a claim except as specifically allowed by MAD regulations. Following MAD payment, a provider cannot seek additional payment from an eligible recipient or their personal representative in addition to the amount paid by MAD. Following MAD denial of payment due to provider administrative error in filing a claim, a provider cannot seek payment from an eligible recipient or their personal representative or turn the balance over to collection. See 8.302.3 NMAC, *Third Party Liability Provider Responsibilities*.

[8.302.1.15 NMAC - Rp, 8.302.1.15 NMAC, 7/1/2024]

8.302.1.16 ACCEPTANCE OF RECIPIENT OR THIRD PARTY PAYMENTS: A provider may only bill an eligible recipient or accept payment for services if all of the following requirements are satisfied:

A. The eligible recipient is advised by the provider before services are furnished that a particular service is not covered by MAD or that the particular provider does not accept patients whose medical services are paid for by MAD.

B. The eligible recipient is provided with information by the provider regarding the necessity, options, and charges for the service, and of the option of going to a provider who accepts MAD payment.

C. The eligible recipient still agrees in writing to have specific services provided with the knowledge that he will be financially responsible for payment.

[8.302.1.16 NMAC - Rp, 8.302.1.16

NMAC, 7/1/2024]

8.302.1.17 RECORD KEEPINGANDDOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. (42 CFR 431.107(b)). Services billed to MAD not substantiated in the eligible recipient's records are subject to recoupment. Failure to maintain records for the required time period is a violation of the Medicaid Provider Act, Section 27-11-1, et. seq. NMSA 1978, and a crime punishable under the Medicaid Fraud Act, Section 30.44-5 NMSA 1978. See 8.351.2 NMAC, *Sanctions and Remedies*.

A. Detail required in records: Provider records must be sufficiently detailed to substantiate the date, time, eligible recipient name, rendering, attending, ordering or prescribing provider; level and quantity of services; length of a session of service billed, diagnosis and medical necessity of any service.

(1) When codes, such as the international classification of disease (ICD) or current procedural terminology (CPT), are used as the basis for reimbursement, provider records must be sufficiently detailed to substantiate the codes used on the claim form.

(2) Treatment plans or other plans of care must be sufficiently detailed to substantiate the level of need, supervision, and direction and service(s) needed by the eligible recipient.

B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.

C. Services billed by units of time: Services billed on the basis of time units spent with an eligible recipient must be sufficiently detailed to document the actual time spent with the eligible recipient and the services provided during that time unit.

D. Recipient funds accounting systems: If an eligible recipient entrusts their personal funds to a nursing facility, intermediate care facility for the intellectually disabled, or swing bed hospital, or any other facility, the facility provider must establish and maintain an acceptable system of accounting. See 42 CFR 445.22.

E. Record retention: A provider who receives payment for treatment, services, or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date:

(1) treatment or care of any eligible recipient;

(2) services or goods provided to any eligible recipient;

(3) amounts paid by MAD on behalf of any eligible recipient; and

(4) any records required by MAD for the administration of medicaid.

[8.302.1.17 NMAC - Rp, 8.302.1.17 NMAC, 7/1/2024]

8.302.1.18 PATIENT CONFIDENTIALITY: A provider is required to comply with the HIPAA privacy regulations. Confidential medical information regarding medicaid information on the applicant or eligible recipient must be released by providers to MAD, and to other state or federal agencies, or their employees at no cost when:

A. the agency is involved in the administration of medicaid;

B. the information is to be used to establish eligibility, determine the amount of assistance or provide services related to medicaid;

C. the agency is subject to the same standards of confidentiality as MAD; and

D. the agency has the actual consent of applicant or eligible recipient or their personal representative for release of the information, or consent is obtained when an eligible recipient or their personal representative or a member of the assistance group makes application for benefits or services with the HCA.

[8.302.1.18 NMAC - Rp, 8.302.1.18 NMAC, 7/1/2024]

8.302.1.19 PROVIDER DISCLOSURE: A provider must furnish MAD with the following information. See 42 CFR 431.107(b)(2)(3): name and address of each person with an ownership or controlling interest in the entity or in any subcontractor in which the entity has a direct or indirect ownership interest totaling five percent or more, and any relationship (spouse, child or sibling) of these persons to another; name of any other entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest; name of any person with an ownership or controlling interest in the entity who has been convicted of a criminal offense related to that person's involvement in any program established under the medicare or medical assistance programs; and name of any provider who employs or uses the services of an individual who, at any time during the year preceding this employment, was employed in a managerial, accounting, auditing or similar capacity, by an agency or organization which currently serves or at any time during the preceding year served as a medicare or MAD fiscal intermediary or carrier for the provider. A provider must notify MAD of any change in the status of these disclosure provisions.

A. Reports furnished by providers: A provider must give MAD, the appropriate MAD claims processing contractor, MAD audit contractor, MAD utilization review contractor or MAD designated representative financial reports, audits, certified cost statements, medical and other records, or any other data needed to establish a basis for reimbursement at no cost.

(1) All information regarding any claim for

services must be provided. See 42 CFR 431.107(b) (2).

(2) Required cost statements must be furnished no later than 150 calendar days of the close of the provider's fiscal accounting period.

(3) MAD records and other documentation needed by MAD or its designee must be available within a defined period, upon request.

B. Penalties: MAD suspends payment for services until the required statements are furnished by the provider.

C. Conflict of interest: MAD does not enter into a provider participation agreement or other contract with a public officer, employee of the state, legislator, or business in which the individual has a substantial interest, unless the individual discloses their substantial interest and provider participation agreement is accepted by MAD and any other contract is awarded pursuant to the state procurement code [Section 10-16-7 NMSA 1978 (Repl. Pamp. 1993)].

[8.302.1.19 NMAC - Rp, 8.302.1.19 NMAC, 7/1/2024]

8.302.1.20 TERMINATION OF PROVIDER STATUS:

A. Provider status may be terminated if the provider or MAD gives the other written notice of termination at least 60 calendar days before the effective termination date.

(1) Facility provider must also give at least 15 calendar days notice to the public by publishing a statement of the date services are no longer available at the facility in one or more newspapers of general circulation within the affected county or region.

(2) Normal termination and notice limits do not apply if the state survey agency or health care financing administration determines that the health and safety of residents in a nursing facility or intermediate care facility for the intellectually disabled or the children, youth and families department determines that the health and safety of children or adolescents in a residential treatment center, group home, or treatment foster care are in jeopardy.

B. Grounds for denial or revocation of enrollment: MAD may, with a 30-calendar days notice, deny or terminate a provider's enrollment in its medical assistance program including, but not limited to, medicaid (Title XIX of the Social Security Act) and other health insurance programs funded by the HCA, if any of the following are found to be applicable to the health care provider, their agent, a managing employee, or any person having an ownership interest equal to five percent or greater in the health care provider:

(1) misrepresentation by commission or omission of any information on the MAD provider participation agreement enrollment form;

(2) previous or current exclusion, suspension, termination from, or the involuntary withdrawal from participation in New Mexico medical assistance programs, any other states medicaid program, medicare, or any other public or private health or health insurance program;

(3) conviction under federal or state law of a criminal offense relating to the delivery of any goods, services, or supplies, including the performance of management or administrative services relating to the delivery of the goods, services, or supplies, under New Mexico medical assistance programs any other states medicaid program, medicare, or any other public or private health or health insurance program;

(4) conviction under federal or state law of a criminal offense relating to the neglect, or abuse of a patient in connection with the delivery of any goods, services, or supplies;

(5) conviction under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance;

(6) conviction under federal or state law of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;

(7) conviction under federal or state law of a criminal offense punishable by imprisonment of a year or more which involved moral turpitude, or acts against the elderly, children, or infirmed;

(8) conviction under federal or state law of a criminal offense in connection with the interference or obstruction of any investigation into any criminal offense listed in Paragraphs (3) through (9) of this subsection;

(9) sanction pursuant to a violation of federal or state laws or rules relative to New Mexico medical assistance programs, any other state's medicaid program, medicare, or any other public health care or health insurance program;

(10) violation of licensing or certification conditions or professional standards relating to the licensure or certification of health care providers or the required quality of goods, services, or supplies provided;

(11) failure to pay recovery properly assessed or pursuant to an approved repayment schedule under New Mexico medical assistance programs; and

(12) see 8.351.2 NMAC, *Sanctions and Remedies,* and 8.353.2 NMAC, *Provider Hearings*.

[8.302.1.20 NMAC - Rp, 8.302.1.20 NMAC, 7/1/2024]

8.302.1.21 CHANGE IN OWNERSHIP: As soon as possible, but at least 60 calendar days after a change in ownership, MAD reserves the right to withhold payment on all pending or current claims until any right MAD has to recoup portions or all of those payments is determined. Payment will not be withheld if MAD received written confirmation that the new owner or previous medical assistance program provider agrees

to be responsible for any potential overpayment.
[8.302.1.21 NMAC - Rp, 8.302.1.21 NMAC, 7/1/2024]

8.302.1.22 PUBLIC DISCLOSURE OF SURVEY INFORMATION: The findings of a MAD survey used to determine the ability of facility provider to begin or continue as medicaid participating provider is available to the public within 90 calendar days of completion.

A. Documents subject to disclosure: Documents subject to public disclosure include:

(1) current survey reports prepared by the survey agency;

(2) official agency notifications of findings based on these reports, including statements of deficiencies;

(3) pertinent parts of written statements furnished by providers to the survey agency related to these reports and findings, including any corrective action taken or planned; and

(4) information regarding the ownership of nursing facility. See 42 CFR 455.104(a).

B. Release of performance reports: Reports on provider's or contractor's performance reviews and formal performance evaluations are not available to the public until the provider or contractor have a reasonable opportunity (not to exceed 30 calendar days) to review the reports and offer comments. These comments become part of the reports.

C. Availability of cost reports: Provider cost reports used as a basis for reimbursement are available to the public upon receipt of a written request by the MAD audit contractor.

(1) Information disclosure is limited to cost report documents required by social security administration regulations, and in the case of a settled cost report, the notice of medicaid settlement.

(2) The request for information must identify the provider and the specific reports requested.

(3) The cost for supplying copies of the cost reports is billed to the requester.
[8.302.1.22 NMAC - Rp, 8.302.1.22 NMAC, 7/1/2024]

HISTORY OF 8.302.1 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the commission of public records - state records center and archives.
ISD 301.2000, Provider Agreement; 12/21/1979.
ISD 301.2000, Provider Agreement, 12/4/1980.
MAD RULE 301, Procedures and Requirements for Provider Participation, 11/8/1989.
ISD 301.3000, Confidentiality, 12/21/1979.
ISD 301.4000, Public Disclosure of Information, 1/17/1980.
ISD 301.4000, Public Disclosure of Information, 11/24/1980.
SP-004.1300, Section 4, General Program Administration Required Provider Agreement, 3/3/1981.
SP-007.0200, Section 7, General Provisions Nondiscrimination, 3/4/1981.
SP-004.2300, Section 4, General Program Administration Use of Contracts, 3/5/1981.
SP--004.2700, Section 4, General Program Administration Disclosure of Survey Information and Provider or Contractor Evaluation, 3/5/1981.
SP-004.3100, Section 4, General Program Administration Disclosure of Information By Providers and Fiscal Agents, 3/5/1981.
SP-007.0201, Section 7, Nondiscrimination, 6/10/1981.
SP-003.0100, Medical and Remedial Care and Services- Amount, Duration and Scope, 6/18/1981.
SP-003.0100, Section 3, Services: General Revisions - Amount, Duration and Scope of Service, 6/24/1981.

History of Repealed Material:
8.302.1 NMAC, Medicaid General Provider Policies - General Provider Policies filed 6/14/2001 - Repealed effective 1/1/2023.
8.302.1 NMAC - General Provider Policies (filed 12/9/2022) Repealed effective 7/1/2024.

Other: 8.302.1 NMAC, Medicaid General Provider Policies - General Provider Policies filed 6/14/2001 Replaced by 8.302.1 NMAC, Medicaid General Provider Policies - General Provider Policies effective 1/1/2023.
8.302.1 NMAC - General Provider Policies (filed 12/9/2022) Replaced by 8.302.1 NMAC - General Provider Policies effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 302 MEDICAID GENERAL PROVIDER POLICIES
PART 4 OUT-OF-STATE AND BORDER AREA PROVIDERS

8.302.4.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.302.4.1 NMAC - Rp 8.302.4.1 NMAC, 7/1/2024]

8.302.4.2 SCOPE: The rule applies to the general public.
[8.302.4.2 NMAC - Rp 8.302.4.2 NMAC, 7/1/2024]

8.302.4.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under the Social Security Act as amended, or by state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and

health care purchasing and regulation.
[8.302.4.3 NMAC - Rp 8.302.4.3 NMAC, 7/1/2024]

8.302.4.4 DURATION: Permanent.
[8.302.4.4 NMAC - Rp 8.302.4.4 NMAC, 7/1/2024]

8.302.4.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.302.4.5 NMAC - Rp 8.302.4.5 NMAC, 7/1/2024]

8.302.4.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs.
[8.302.4.6 NMAC - Rp 8.302.4.6 NMAC, 7/1/2024]

8.302.4.7 DEFINITIONS: [**RESERVED**]

8.302.4.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico and to assure low income and individuals with disabilities in New Mexico equal participation in the life of their communities.
[8.302.4.8 NMAC - Rp 8.302.4.8 NMAC, 7/1/2024]

8.302.4.9 OUT-OF-STATE AND BORDER AREA PROVIDERS: Border area services are those that are rendered within 100 miles of the New Mexico state border (Mexico excluded). Out-of-state services are those that are rendered in an area more than 100 miles from the New Mexico border (Mexico excluded). To help New Mexico eligible recipients receive medically necessary services, the medical assistance division (MAD) pays for border area services to the same extent and subject to the same rules and requirements that such services are covered when provided within the state. MAD pays for out-of-state services as described under 8.302.4.12 NMAC, *covered out-of-state services.*
[8.302.4.9 NMAC - Rp 8.302.4.9 NMAC, 7/1/2024]

8.302.4.10 ELIGIBLE PROVIDERS: Health care to eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HCA or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. The providers listed in Subsections A-C of 8.302.4.10 NMAC, *eligible providers*, are eligible for a provider participation agreement, bill and receive reimbursement for furnishing medical services:

A. Eligible providers include border area and out-of-state providers licensed by or certified by their respective states to practice medicine or osteopathy [42 CFR Section 440.50 (a)(1)(2)]; and other providers licensed or certified by their state to perform services equivalent to those covered by the medical assistance programs in New Mexico; practices or groups formed by these individuals may also receive reimbursement for services.

B. Eligible providers include border area providers within 100 miles of the New Mexico state border (Mexico excluded), subject to the rules governing the provision of services for an in-state provider.

C. Eligible providers include out-of-state providers more than 100 miles from the New Mexico state border (Mexico excluded), subject to the rules governing the provision of services for an in-state provider and any additional rules that may be specified for the specific services and providers within this manual.
[8.302.4.10 NMAC - Rp 8.302.4.10 NMAC, 7/1/2024]

8.302.4.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to a medicaid or other health care program eligible recipient must comply with all federal and state laws, regulations and executive orders relevant to the provision of services as specified in the MAD provider participation agreement. A provider also must conform to MAD program rules and instructions as specified in the provider rules manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and the centers for medicaid and medicare (CMS) correct coding initiatives, including not improperly unbundling or upcoding services. When services are billed to and paid by a coordinated services contractor authorized by HCA, the provider must follow that contractor's instructions for billing and for authorization of services.

B. A provider must verify that an individual is eligible for a specific health care program

administered by the HCA and its authorized agents, and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

C. When services are billed to and paid by a MAD fee-for-service coordinated services contractor authorized by HCA, under an administrative services contract, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

[8.302.4.11 NMAC - Rp 8.302.4.11 NMAC, 7/1/2024]

8.302.4.12 COVERED OUT-OF-STATE SERVICES: MAD covers services and procedure furnished by a provider located within 100 geographical miles of the New Mexico border, even though the road miles may be greater than 100 miles, to the same extent and using the same coverage rules as for an in-state provider. See 8.302.4.9 NMAC, *out of state and border area providers*. When it is the general practice for an eligible recipient in a New Mexico locality to access medical services in a location more than 100 geographical miles from the New Mexico border, MAD will treat that out-of-state location as a border area. MAD covers services and procedures furnished by a provider more than 100 geographical miles from the New Mexico border, excluding Mexico, to the extent and using the same coverage rules as for in-state provider when one or more of the following conditions are met.

A. An eligible recipient is out-of-state at the time the services are needed and the delivery of services is of an emergent or urgent nature or if the eligible recipient's health would be endangered by traveling back to New Mexico. Services must be medically necessary to stabilize the eligible recipient's health and prevent significant adverse health effects, including preventable hospitalization. Claims for such services are subject to pre-payment or post-payment reviews to assure the emergent or urgent need or medical necessity of the services.

B. On-going-services provided by a medical assistance program within the state continue to be necessary when the eligible recipient is visiting another state.

C. Care is medically necessary for an eligible recipient that is placed by the state of New Mexico in foster care in an out-of-home placement or in an institution. Care is medically necessary for an eligible recipient that was adopted from New Mexico and resides out-of-state. If the agreement with the other state requires that state's medicaid program pay for covered services, MAD will only consider payment when a service is not covered by the other state and the eligible recipient would be eligible for that service if living in New Mexico.

D. Durable medical equipment, medical supplies, prosthetics or orthotics are purchased from out-of-state vendors.

E. Clinical laboratory tests, radiological interpretations, professional consultations or other services are performed by out-of-state laboratories but do not require the eligible recipient to leave the state.

F. Medical services or procedures considered medically necessary are not available in the state of New Mexico. All services that are not available in New Mexico require prior authorization when provided by an out-of-state provider. An out-of-state service may be limited to the closest provider or an otherwise economically prudent choice of provider capable of rendering the service.

G. Services, such as personal assistance, are needed by an eligible recipient out-of-state if that recipient is eligible to receive services through a medicaid home and community-based services waiver program and is traveling to another state.

[8.302.4.12 NMAC - Rp 8.302.4.12 NMAC, 7/1/2024]

8.302.4.13 NONCOVERED SERVICES: Services furnished by an out-of-state or border provider are subject to the limitations and coverage restrictions which exist for other services rendered in-state as stated in the relevant administrative, provider, and other services sections of the MAD program policy manual. In addition, MAD programs do not cover the following specific services when furnished by an out-of-state or border provider:

A. services furnished outside the boundaries of the United States; and

B. services furnished in an out-of-state or border area nursing facility or intermediate care facility for the mentally retarded.

[8.302.4.13 NMAC - Rp 8.302.4.13 NMAC, 7/1/2024]

8.302.4.14 OUT-OF-STATE HOSPITAL SERVICES: All out-of-state hospital, and other residential service claims are subject to prepayment review or periodic re-authorization by MAD or its designee for medical necessity and length of stay, in addition to requiring authorization for the initial placement.

[8.302.4.14 NMAC - Rp 8.302.4.14 NMAC, 7/1/2024]

8.302.4.15 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished, and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, a provider receives instructions on how to access utilization review documents necessary for prior approval and claims processing.

A. Prior authorization: Certain procedures or services can

require prior approval from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process. A service provided through an out-of-state or border provider is subject to the same prior authorization and utilization review requirements, which exist for the service when not provided out-of-state.

B. Eligibility determination: Prior authorization of services does not guarantee an individual is eligible for medicaid and other health care programs. A provider must verify that an individual is eligible for a specific program at the time services are furnished and must determine if the eligible recipient has other health insurance.

C. Reconsideration: A provider who disagrees with prior authorization request denials and other review decisions can request a re-review and a re-consideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions.*

[8.302.4.15 NMAC - Rp 8.302.4.15 NMAC, 7/1/2024]

8.302.4.16 OUT-OF-STATE BILLING OFFICES: Services furnished within the state or border areas are subject to the rules for in-state providers even if the billing or administrative office is outside the state.

[8.302.4.16 NMAC - Rp 8.302.4.16 NMAC, 7/1/2024]

8.302.4.17 REIMBURSEMENT: Reimbursement to an out-of-state or border area provider is made at the same rate as for an in-state provider except as otherwise stated in the relevant specific providers and services sections of the MAD program rules manual.

A. Unless payment for a service is made using a diagnosis related group or outpatient prospective payment system rate, reimbursement to a provider for covered services is made at the lesser of the following:

(1) the billed change which must be the provider's usual and customary charge for service; "usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service; or

(2) the MAD fee schedule for the specific service or procedure.

B. When a provider and an MCO are unable to agree to terms or fail to execute an agreement for any reason, the MCO shall be obligated to pay, and the provider shall accept, one hundred percent of the "applicable reimbursement rate" based on the provider type for services rendered under both emergency and non-emergency situations. The "applicable reimbursement rate" is defined as the rate paid by HCA to a provider participating in medicaid or other medical assistance programs administered by HCA and excludes disproportionate share hospital and medical education payments.

[8.302.4.17 NMAC - Rp 8.302.4.17 NMAC, 7/1/2024]

HISTORY OF 8.302.4 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 303.1000, Covered Services, filed 1/7/1980.
ISD 303.1000, Covered Services, filed 4/2/1982.
MAD Rule 303, Benefits, filed 11/8/1989.
MAD Rule 303, Benefits, filed 4/17/1992.
MAD Rule 303, Benefits, filed 3/10/1994.
SP-004.1700, Section 4, General Program Administration Liens and Recoveries, filed 3/5/1981.

History of Repealed Material:
MAD Rule 303, Benefits, filed 3/10/94 - Repealed effective 2/1/1995.
8.302.4 NMAC - Out-Of-State And Border Area Providers (filed 7/24/2008) Repealed effective 7/1/2024.

Other: 8.302.4 NMAC - Out-Of-State And Border Area Providers (filed 7/24/2008) Replaced by 8.302.4 NMAC - Out-Of-State And Border Area Providers effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 4 FEDERALLY QUALIFIED HEALTH CENTER SERVICES

8.310.4.1 ISSUING AGENCY: New Mexico Health Care Authority.

[8.310.4.1 NMAC - Rp 8.310.4.1 NMAC, 7/1/2024]

8.310.4.2 SCOPE: The rule applies to the general public.

[8.310.4.2 NMAC - Rp 8.310.4.2 NMAC, 7/1/2024]

8.310.4.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.310.4.3 NMAC - Rp 8.310.4.3 NMAC, 7/1/2024]

8.310.4.4 DURATION: Permanent.

[8.310.4.4 NMAC - Rp 8.310.4.4 NMAC, 7/1/2024]

8.310.4.5 EFFECTIVE DATE: July 1, 2024, unless a later

date is cited at the end of a section.
[8.310.4.5 NMAC - Rp 8.310.4.5 NMAC, 7/1/2024]

8.310.4.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.310.4.6 NMAC - Rp 8.310.4.6 NMAC, 7/1/2024]

8.310.4.7 DEFINITIONS: [**RESERVED**]

8.310.4.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.310.4.8 NMAC - Rp 8.310.4.8 NMAC, 7/1/2024]

8.310.4.9 FEDERALLY QUALIFIED HEALTH CENTER SERVICES: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible clients. To help New Mexico clients receive necessary services, the New Mexico medical assistance division (MAD) pays for covered outpatient services provided at federally qualified health centers (FQHC's). This part describes eligible providers, covered services, service limitations, and general reimbursement methodology. MAD intends to follow federal regulation applicable to medicare where and if there are any omissions in these regulations with respect to covered services.
[8.310.4.9 NMAC - Rp 8.310.4.9 NMAC, 7/1/2024]

8.310.4.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by MAD, the following entities are eligible to be reimbursed for furnishing medical services as FQHCs:

(1) entities which receive a grant under Sections 245b, 254c, and 256 of the Social Security Act;

(2) entities which receive funding from such a grant under a contract with the recipient of such a grant indicated above which meet the requirements to receive a grant under Sections 245b, 254c, and 256 of the Social Security Act;

(3) entities which the secretary of the federal department of health and human services determines meet the requirements for receiving such a grant or entities which qualify through waivers authorized by the secretary of the department of health and human services; and

(4) outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organizations receiving funds under the Indian Health Care Improvement Act for the provision of primary health services.

B. Individual providers employed by or under contract with FQHCs must be enrolled with New Mexico medicaid.

C. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.
[8.310.4.10 NMAC - Rp 8.310.4.10 NMAC, 7/1/2024]

8.310.4.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid clients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid clients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to clients. See 8.302.1 NMAC, *General Provider Policies*.
[8.310.4.11 NMAC - Rp 8.310.4.11 NMAC, 7/1/2024]

8.310.4.12 COVERED SERVICES: All services provided by the FQHC must be furnished in accordance with applicable federal, state, and local laws and regulations and must be furnished within the limitations applicable to medicaid-covered benefits. If not specified in this section, MAD adopts definitions of coverage delineated in the FQHC sections of medicare statutes. "Other ambulatory services" offered by the FQHC are subject to the same medicaid limitations, utilization review requirements, and coverage restrictions that exist for other providers rendering the delineated service.

A. Physician services:

(1) Physician services are professional services that are performed by a physician, including psychiatrists, employed by or under contract with the FQHC.

(2) Services and supplies incident to a physician's professional service are covered if the service or supply meets delineated requirements. Services and supplies include the professional component of radiology services, laboratory services performed by the FQHC and specimen collection for laboratory services furnished by an off-site laboratory. To meet the definition of "incident to" a professional service, the service and supplies must be:

(a) of a type commonly furnished in a physician's office; within the meaning of the Code of Federal Regulations (CFR) page 128 Section 405.2413 (a) (1) 10-01-98 edition;

(b) of a type commonly rendered either without charge or included in the FQHC encounter rate;

(c) furnished as an incidental, although integral, part of a physician's professional service;

(d) furnished under direct, personal supervision of a physician; and

(e) in the case of a service, furnished by a member of the FQHC's health care staff who is an employee of the FQHC or under contract with the FQHC.

(3) Inpatient hospital visits are those services furnished to an individual as a "patient" of the FQHC. Therefore, FQHC services furnished off-site (including those furnished to a person who is an inpatient of a hospital or nursing facility) will be considered FQHC services only if the physician's agreement with the FQHC requires that they seek compensation from the FQHC. (Section 4704 c of OBRA '90, amended Section 1905 1,2.) (HCFA Letter #91-18 dated March 1991.)

B. Mid-level practitioners: Services furnished by a nurse practitioner, physician assistant, nurse midwife, or specialized nurse practitioner are covered as an FQHC core service if the service is:

(1) furnished by a nurse practitioner, physician assistant, nurse midwife, or specialized nurse practitioner who is employed by or under contract with the FQHC;

(2) furnished in accordance with FQHC policies and individual treatment plans developed by FQHC personnel for a given client;

(3) a type which the nurse practitioner, physician assistant, nurse midwife or specialized nurse practitioner who furnished the service is permitted by licensure or certification;

(4) furnished under the supervision of a physician, if required by New Mexico law.

(a) The physician supervision requirement is met if the conditions specified in Section 491.8 (b) of the Social Security Act and any pertinent requirements specified under New Mexico law are satisfied.

(b) To be covered, the services provided by mid-level practitioners must comply with New Mexico law.

(c) Services and supplies are covered as incident to the provision of services by a mid-level practitioner if the requirements specified in Paragraph (2) of Subsection A of 8.310.4.12 NMAC are met.

(d) The direct personal supervision requirement for mid-level practitioners is met if the mid-level practitioner is permitted to supervise under the written policies governing the FQHC and as defined under New Mexico law.

C. Outpatient mental health services: Diagnosis and treatment of mental illness are covered services when the service is provided by an individual licensed as a physician by the board of medical examiners or board of osteopathy and who is board-eligible or board-certified in psychiatry, a licensed clinical psychologist (Ph.D., Psy. D., or Ed. D.), a licensed independent social worker (LISW), a licensed professional clinical mental health counselor (LPCC), a licensed marriage and family therapist (LMFT), or a clinical nurse specialist certified in psychiatric nursing (CNP) who is employed by or under contract with the FQHC. An FQHC is reimbursed for services furnished by licensed master's level social workers, licensed psychology associates and master's level licensed counselors who are graduates of an accredited program when the services are furnished under the direction and supervision as addressed under Subsection C of 8.310.8.10 NMAC.

D. Visiting nurse services: Visiting nurse services are covered if the FQHC is located in an area identified by the secretary of health and human services as having a shortage of home health agencies. No additional certification is required beyond the FQHC certification. To be covered, visiting nurse services must be:

(1) rendered to clients who meet criteria for home health services;

(2) furnished by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by or under contract with the FQHC; and

(3) furnished under a written plan of treatment that is established and signed by a supervising physician; the plan may also be established by a nurse practitioner, physician assistant, nurse midwife, or specialized nurse practitioner employed by or under contract with the FQHC; the plan must be reviewed every 60 days by the supervising physician and revised as the client's condition warrants;

(4) visiting nurse services do not include household and housekeeping services or other services that constitute custodial care.

E. Preventive services:

(1) Preventive primary services that an FQHC may provide are those services as defined in the 42 CFR 405.2448 and include:

(a) medical social services;

(b) nutritional assessment and referral;

(c) individual preventive health education;

(d) well-child care, including periodic screening, to include children's eye and ear examinations;

(e) prenatal and postpartum care;

(f) immunizations for children and adults, including tetanus-diphtheria booster and influenza vaccine;

(g) family planning services;

(h) physical examinations targeted to risk, to include blood pressure measurement, weight, and client history;

(i) visual acuity screening;

(j) hearing screening;

(k) cholesterol screening;

(l) stool testing for occult blood;

(m) dipstick urinalyses;

(n) risk assessment and initial counseling regarding risks;

(o) tuberculosis testing for high risk clients;

(p) preventive dental services;

(q) for women only: PAP smears; clinical breast exams; referral for mammography; and thyroid function tests.

(2) Documentation of any service provided by the FQHC must be available in the client's record.

(3) Preventive primary services do not include eyeglasses, hearing aids, group or mass information programs, health education classes, or group education activities, including media productions and publications.

F. Pharmacy services: Pharmacy services and medical supplies are covered services and are included as an allowable cost if dispensed from an FQHC. An FQHC encounter for the provision of medical, behavioral health, and dental services includes related pharmacy services. The FQHC shall not bill a separate encounter for the provision of pharmacy services. To dispense medications, the FQHC must be licensed as a licensed drug clinic under the Pharmacy Practice Act.

G. Dental services: See 8.310.7 NMAC, *Dental Services*, for benefit coverage and service limitation. Dentists and dental hygienists providing services for an FQHC must provide services within the scope of their license as defined in the New Mexico Dental Health Care Act.

H. Case management: Targeted case management services are covered services and are subject to the same requirements that apply to providers who furnish case management services. 8.326.2 NMAC through 8.326.8 NMAC (MAD-771 - MAD-779).

[8.310.4.12 NMAC - Rp 8.310.4.12 NMAC, 7/1/2024]

8.310.4.13 UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Approval and Utilization Review*. Once enrolled, providers receive instruction and documentation forms necessary for prior approval and claims processing.

A. Prior approval: Certain procedures and services can require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior approval of services does not guarantee that the individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid clients have other health insurance.

C. Reconsideration: Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions.*

[8.310.4.13 NMAC - Rp 8.310.4.13 NMAC, 7/1/2024]

8.310.4.14 NON-COVERED SERVICES AND SERVICE LIMITATION: FQHC services are covered when provided in outpatient settings only, including a client's place of residence, which may be a skilled nursing facility or a nursing facility or other institution used as a client's home. FQHC services are not covered in a hospital as defined in section 1861(e)(1) of the Act.

A. Service limitations: An FQHC may be compensated for provision of other "ambulatory services" covered in the medicaid fee-for-service program (per the Balanced Budget Act of 1997). However, an FQHC must meet licensing and certification requirements for those services as specified in the applicable MAD policy manual section for the specific service.

B. Location of clinic:

(1) Permanent unit: Objects, equipment, and supplies necessary for the provision of services furnished directly by the FQHC must be housed in a permanent structure. Each unit must have individual FQHC certification.

(2) Mobile unit: The objects, equipment, and supplies necessary for the provision of services furnished by the FQHC must be housed in an FQHC mobile structure which has fixed, scheduled locations.

C. Other restrictions: FQHC service providers are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Non-covered Services.*

[8.310.4.14 NMAC - Rp 8.310.4.14 NMAC, 7/1/2024]

8.310.4.15 REIMBURSEMENT: FQHCs must submit claims for reimbursement on the UB-92 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Interim reimbursement for services provided by an FQHC is made by MAD based on submitted claims.

A. Initial rates: The initial interim rate for new FQHC providers will be the interim rate set by medicare.

B. Cost settlement:

(1) FQHCs must submit cost reports on an annual basis to MAD or its designee within the time frames specified by medicare. FQHCs will not be granted an extension to the cost report filing

time frames.

(2) A final cost settlement based on the audit data will be made in accordance with delineated medicaid requirements or applicable medicare cost reimbursement principles when medicaid requirements are not specified. Final cost settlements are based on the allowable cost as audited or desk reviewed costs by MAD or its designee. "Allowable costs" are costs incurred by an FQHC which are reasonable in amount, proper and necessary for the efficient delivery of services by the FQHC (MAD or its designee will follow the HCFA Pub. 15-1 in determining allowable costs). The supporting documentation for "allowable costs" must be available upon request from MAD or its designee.

(3) MAD or its designee may reopen cost reports per HCFA Pub. 15-1 Section 2931 through 2932.1. Providers will be notified on a case-by-case basis thirty (30) days prior to any reopening. MAD uses the productivity standards used in the medicare cost report. However, MAD does not use the costs limits imposed by medicare. If an FQHC disagrees with an audit settlement, the provider can request a reconsideration. See 8.350.4 NMAC, *Reconsideration of Audit Settlement.*

(4) HCA or its designee will complete their initial review of cost settlement materials within 150 days of the receipt of all required information.

C. What constitutes a visit: A visit is a face-to-face encounter between a center client and a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, qualified clinical psychologist or qualified clinical social worker. Encounters with more than one health professional and multiple encounters with the same health professional on the same day and at a single location constitute a single visit, except when one of the following conditions exist:

(1) after the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment;

(2) the client has a dental visit, or medical visit and another health visit (e.g., a face-to-face encounter between the client and a clinical psychologist, clinical social worker, or other health professional for mental health services listed in Subsection C of 8.310.4.12 NMAC

D. Supplemental agreements: FQHCs which executed specific agreements with HCA will receive supplemental payments for services rendered to clients enrolled in managed care in the manner and amount specified under the terms of that agreement.

E. Termination or change of ownership: The HCA reserves the right to withhold payment on all current and pending claims until HCA rights to recoup all or portions of such payments is determined from final cost reports when a change of ownership occurs. Payment will not be withheld if HCA is informed in writing the current (new) owner or the previous owner agrees to be responsible for any potential recoupment.
[8.310.4.15 NMAC - Rp 8.310.4.15 NMAC, 7/1/2024]

HISTORY OF 8.310.4 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
MAD Rule 310.29, Federally Qualified Health Centers (FQHC), filed 5/21/1991.

History Of Repealed Material:
MAD Rule 310.29, Federally Qualified Health Centers (FQHC), filed 5/21/1991 - Repealed effective 2/1/1995.
8.310.4 NMAC - Federally Qualified Health Center Services (filed 10/12/2004) Repealed 7/1/2024.

Other: 8.310.4 NMAC - Federally Qualified Health Center Services (filed 10/12/2004) Replaced by 8.310.4 NMAC - Federally Qualified Health Center Services effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 311 HOSPITAL SERVICES
PART 2 HOSPITAL SERVICES

8.311.2.1 ISSUING AGENCY: Health Care Authority.
[8.311.2.1 NMAC - Rp 8.311.2.1 NMAC, 7/01/2024]

8.311.2.2 SCOPE: This rule applies to the general public.
[8.311.2.2 NMAC - Rp 8.311.2.2 NMAC, 7/01/2024]

8.311.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under the Social Security Act as amended, or by state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.311.2.3 NMAC - Rp 8.311.2.3 NMAC, 7/01/2024]

8.311.2.4 DURATION: Permanent
[8.311.2.4 NMAC - Rp 8.311.2.4 NMAC, 7/01/2024]

8.311.2.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.311.2.5 NMAC - Rp 8.311.2.5 NMAC, 7/01/2024]

8.311.2.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.311.2.6 NMAC - Rp 8.311.2.6 NMAC, 7/01/2024]

8.311.2.7 DEFINITIONS: [**RESERVED**]

8.311.2.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance. [8.311.2.7 NMAC - Rp 8.311.2.7 NMAC, 7/01/2024]

8.311.2.9 HOSPITAL SERVICES: The New Mexico medical assistance division (MAD) pays for medically necessary health services furnished to eligible recipients. To help New Mexico eligible recipients receive necessary services, MAD pays for inpatient, outpatient, and emergency services furnished in general hospital settings. [8.311.2.8 NMAC - Rp 8.311.2.8 NMAC, 7/01/2024]

8.311.2.10 ELIGIBLE PROVIDERS: Health care to eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HCA or its authorized agents to obtain answers to questions related to the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Eligible providers include:

A. a general acute care hospital, rehabilitation, extended care or other specialty hospital:

(1) licensed by the New Mexico department of health (DOH), and

(2) participating in the Title XVIII (medicare) program or accredited by the joint commission (previously known as JCAHO accreditation);

B. a rehabilitation inpatient unit or a psychiatric unit in an inpatient hospital (referred to as a prospective payment system exempt unit (PPS-exempt));

C. a free-standing psychiatric hospital may be reimbursed for providing inpatient and outpatient services to an eligible recipient under 21 years of age; see 8.321.2 NMAC*, Inpatient Psychiatric Care in Free-Standing Psychiatric Hospitals;*

D. a border area and out-of-state hospital is eligible to be reimbursed by MAD if its licensure and certification to participate in its state medicaid or medicare program is accepted in lieu of licensing and certification by MAD; and

E. a hospital certified only for emergency services is reimbursed for furnishing inpatient and outpatient emergency services for the period during which the emergency exists.
[8.311.2.10 NMAC - Rp 8.311.2.10 NMAC, 7/01/2024]

8.311.2.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to an eligible recipient must comply with all federal and state laws, regulations and executive orders relevant to the provision of services as specified in the MAD provider participation agreement. A provider also must conform to MAD program rules and instructions as specified in the provider rules manual and its appendices, as well as current program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify that an individual is eligible for a specific health care program administered by the HCA and its authorized agents and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient. See 8.302.1 NMAC, *General Provider Policies*.

C. A provider agrees to be paid by the MAD managed care organizations (MCOs) at any amount mutually-agreed between the provider and MCOs when the provider enters into contracts with MCOs contracting with HCA for the provision of managed care services to the MAD population.

(1) If the provider and the MCOs are unable to agree to terms or fail to execute an agreement for any reason, the MCOs shall be obligated to pay, and the provider shall accept, one hundred percent of the "applicable reimbursement rate" based on the provider type for services rendered under both emergency and non-emergency situations.

(2) The "applicable reimbursement rate" is defined as the rate paid by HCA to the provider participating in medicaid or other medical assistance programs administered by HCA and excludes disproportionate share hospital and medical education payments.

D. When services

are billed to and paid by a MAD fee-for-service coordinated services contractor authorized by HCA, under an administrative services contract, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.
[8.311.2.11 NMAC - Rp 8.311.2.11 NMAC, 7/01/2024]

8.311.2.12 COVERED SERVICES: MAD covers inpatient and outpatient hospital, and emergency services which are medically necessary for the diagnosis, the treatment of an illness or injury or as required by the condition of the eligible recipient. MAD covers items or services ordinarily furnished by a hospital for the care and treatment of an eligible recipient. These items or services must be furnished under the direction of an enrolled MAD physician, podiatrist, or dentist with staff privileges in a hospital which is an enrolled MAD provider. Services must be furnished within the scope and practice of the profession as defined by state laws and in accordance with applicable federal and state and local laws and regulations.
[8.311.2.12 NMAC - Rp 8.311.2.12 NMAC, 7/01/2024]

8.311.2.13 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services are subject to utilization review for medical necessity and program compliance. Reviews may be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a coordinated services contractor authorized by HCA, the provider must follow that contractor's instructions for authorization of services.

A. Prior authorization: Certain procedures or services may require prior authorization from MAD or its designee. A procedure that requires prior authorization is primarily one for which the medical necessity may be uncertain, which may be for cosmetic purposes, or which may be of questionable effectiveness or long-term benefit.

(1) All transfers from one acute care DRG reimbursed hospital to another DRG reimbursed hospital.

(2) All inpatient stays for a PPS-exempt psychiatric unit of a general acute care hospital requires admission and continued stay reviews.

(3) All inpatient stays in a rehabilitation hospital, a PPS-exempt rehabilitation unit in a general acute care hospital, and an extended care or other specialty hospital requires admission and continued stay reviews.

(4) Outpatient physical, occupational, and speech therapies services require prior authorization.

(5) Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior authorization of services does not guarantee that an individual is eligible for MAD services. A provider must verify that an individual is eligible for the MAD services at the time services are furnished and determine if an eligible recipient has other health insurance.

C. Consideration: A provider who disagrees with a prior authorization request denial or another review decision may request a re-review and a reconsideration. See *MAD-953, Reconsideration of Utilization Review Decisions.*
[8.311.2.13 NMAC - Rp 8.311.2.13 NMAC, 7/01/2024]

8.311.2.14 INPATIENT SERVICES: MAD coverage of some inpatient services may be conditional or limited.

A. Medically warranted days: A general hospital is not reimbursed for days of acute level inpatient services furnished to an eligible recipient as a result of difficulty in securing alternative placement. A lack of nursing facility placement is not sufficient grounds for continued acute-level hospital care.

B. Awaiting placement days:

(1) When the MAD utilization review (UR) contractor determines that an eligible recipient no longer meets the care criteria in a rehabilitation, extended care or other specialty hospital or PPS exempt rehabilitation hospital but requires a nursing facility level of care which may not be immediately located, those days during which the eligible recipient is awaiting placement in a lower level of care facility are termed "awaiting placement days". Payment to the hospital for awaiting placement days is made at the weighted average rate paid by MAD for the level of nursing facility services required by the eligible recipient (high NF or low NF).

(2) When the MAD UR contractor determines that a recipient under 21 years of age no longer meets acute care criteria and it is verified that an appropriate reviewing authority has made a determination that the eligible recipient requires a residential level of care which may not be immediately located, those days during which the eligible recipient is awaiting placement to the lower level of care are termed "awaiting placement days". MAD does not cover residential care for individuals over 21 years of age.

(3) Payment to the hospital for awaiting placement days is made at the weighted average rate paid by MAD for residential services that may have different levels of classification based on the medical necessity for the placement of the eligible recipient. See 8.302.5 NMAC, *Prior Authorization and*

Utilization Review. A separate claim form must be submitted for awaiting placement days.

(4) MAD does not pay for any ancillary services for "awaiting placement days". The rate paid is considered all inclusive. Medically necessary physician visits or**,** in the case of the eligible recipient under 21 years of age requiring residential services, licensed Ph.D. psychologist visits, are not included in this limitations.

C. Private rooms: A hospital is not reimbursed for the additional cost of a private room unless the private room is medically necessary to protect the health of the eligible recipient or others.

D. Services performed in an outpatient setting: MAD covers certain procedures performed in an office, clinic, or as an outpatient institutional service which are alternatives to hospitalization. Generally, these procedures are those for which an overnight stay in a hospital is seldom necessary.

(1) An eligible recipient may be hospitalized if there is an existing medical condition which predisposes the eligible recipient to complications even with minor procedures.

(2) All claims for one- or two-day stays for hospitalization are subject to pre-payment or post-payment review.

E. Observation stay: If a physician orders an eligible recipient to remain in the hospital for less than 24 hours, the stay is not covered as inpatient admission, but is classified as an observation stay. An observation stay is considered an outpatient service.

(1) The following are exemptions to the general observation stay definition:

(a) the eligible recipient dies;

(b) documentation in medical records indicates that the eligible recipient left against medical advice or was removed from the facility by their legal guardian against medical advice;

(c) an eligible recipient is transferred to another facility to obtain necessary medical care unavailable at the transferring facility; or

(d) an inpatient admission results in delivery of a child.

(2) MAD or its designee determines whether an eligible recipient's admission falls into one of the exempt categories or considers it to be a one- or two-day stay.

(a) If an admission is considered an observation stay, the admitting hospital is notified that the services are not covered as an inpatient admission.

(b) A hospital must bill these services as outpatient observation services. However, outpatient observation services must be medically necessary and must not involve premature discharge of an eligible recipient in an unstable medical condition.

(3) The hospital or attending physician can request a re-review and reconsideration of the observation stay decision. See MAD 953*, Reconsideration of Utilization Review Decisions.*

(4) The observation stay review does not replace the review of one- and two-day stays for medical necessity.

(5) MAD does not cover medically unnecessary admissions, regardless of length of stay.

F. Review of hospital admissions: All cases requiring a medical peer review decision on appropriate use of hospital resources, quality of care or appropriateness of admission, transfer into a different hospital, and readmission are reviewed by MAD or its designee. MAD or its designee performs a medical review to verify the following:

(1) admission to acute care hospital is medically necessary;

(2) all hospital services and surgical procedures furnished are appropriate to the eligible recipient's condition and are reasonable and necessary to the care of the eligible recipient;

(3) patterns of inappropriate admissions and transfers from one hospital to another are identified and are corrected; hospitals are not reimbursed for inappropriate admissions or transfers; and

(4) the method of payment and its application by a hospital does not jeopardize the quality of medical care.

G. Non-covered services: MAD does not cover the following specific inpatient benefits:

(1) a hospital service which is not considered medically necessary by MAD or its designee for the condition of the eligible recipient;

(2) a hospital service that requires prior authorization for which the approval was not requested except in cases with extenuating circumstances as granted by MAD or its designee;

(3) a hospital service which is furnished to an individual who was not eligible for MAD services on the date of service;

(4) an experimental or investigational procedure, technology or therapy and the service related to it, including hospitalization, anesthesiology, laboratory tests, and imaging services; see MAD-765*, Experimental or Investigational Procedures or Therapies*;

(5) a drug classified as "ineffective" by the federal food and drug administration;

(6) private duty or incremental nursing services;

(7) laboratory specimen handling or mailing charges; and

(8) formal educational or vocational training services which relate to traditional academic subjects or training for employment.

H. Covered services in hospitals certified for emergency services-only: Certain inpatient and outpatient services may be furnished

by a hospital certified to participate in the Title XVIII (medicare) program as an emergency hospital. MAD reimburses a provider only for treatment of conditions considered to be medical or surgical emergencies. "Emergency" is defined as a condition which develops unexpectedly and needs immediate medical attention to prevent the death or serious health impairment of the eligible recipient which necessitates the use of the most accessible hospital equipped to furnish emergency services.

(1) MAD covers the full range of inpatient and outpatient services furnished to an eligible recipient in an emergency situation in a hospital which is certified for emergency services-only.

(2) MAD reimbursement for emergency services furnished in a hospital certified for an emergency services-only is made for the period during which the emergency exists.

(a) Documentation of the eligible recipient's condition, the physician's statement that emergency services were necessary, and the date when, in the physician's judgment, the emergency ceased, must be attached to the claim form.

(b) An emergency no longer exists when it becomes safe from a medical standpoint to move the eligible recipient to a certified inpatient hospital or to discharge the eligible recipient.

(c) Reimbursement for services in an emergency hospital is made at a percentage of reasonable charges as determined by HCA. No retroactive adjustments are made.

I. Patient self determination act: An adult eligible recipient must be informed of their right to make health decisions, including the right to accept or refuse medical treatment, as specified in the Patient Self-Determination Act. See 8.302.1 NMAC*, General Provider Policies*.

J. Psychiatric services furnished to an eligible recipient under 21 years of age in PPS-exempt units of acute care hospitals: Services furnished to an eligible recipient must be under the direction of a physician. In the case of psychiatric services furnished to an eligible recipient under 21 years of age, these services must be furnished under the direction of board eligible/board certified psychiatrist, or a licensed psychologist working in collaboration with a similarly qualified psychiatrist. The psychiatrist must conduct an evaluation of the eligible recipient, in person, within 24 hours of admission. In the case of an eligible recipient under 12 years of age, the psychiatrist must be board eligible/board certified in child or adolescent psychiatry. The requirement for the specified psychiatrist for an eligible recipient under age 12 and under 21 years of age may be waived when all of the following conditions are met:

(1) the need for admission is urgent or emergent, and transfer or referral to another provider poses an unacceptable risk for adverse patient outcomes; and

(2) at the time of admission, a board eligible/ board certified psychiatrist, or in the case of an eligible recipient under 12 years of age, a child psychiatrist is not accessible in the community in which the facility is located; and

(3) another facility which is able to furnish a board eligible/board certified psychiatrist, or in the case of an eligible recipient under 12 years of age, a child psychiatrist, is not available or accessible in the community; and

(4) the admission is for stabilization only and transfer arrangements to the care of a board eligible/ board certified psychiatrist, or in the case of an eligible recipient under 12 years of age, a child psychiatrist is made as soon as possible with the understanding that if the eligible recipient needs to transfer to another facility, the actual transfer will occur as soon as the eligible recipient is stable for transfer, in accordance with professional standards.

K. Reimbursement for inpatient services: MAD reimburses for inpatient hospital services using different methodologies. See 8.311.3 NMAC, *Methods and Standards for Establishing Payment Rates - Inpatient Hospital Services.*

(1) All services or supplies furnished during the hospital stay are reimbursed by the hospital payment amount and no other provider may bill for services or supplies; an exception to this general rule applies to durable medical equipment delivered for discharge and ambulance transportation.

(2) A physician's services are not reimbursed to a hospital under hospital services regulations, but may be payable as a professional component of a service. See 8.310.2 NMAC, *Medical Services Providers*, for information on the professional component of services.

(3) Transportation services are billed as part of a hospital claim if the hospital is DRG reimbursed and transportation is necessary during the inpatient stay.

(a) Transportation is included in a DRG payment when an eligible recipient is transported to a different facility for procedure(s) not available at the hospital where the eligible recipient is a patient.

(b) Exceptions are considered for air ambulance services operated by a facility when air transportation constitutes an integral part of the medical services furnished by the facility. See 8.324.7 NMAC, *Transportation Services.*

L. Reimbursement limitations for capital costs: Reimbursement for capital costs follows the guidelines set forth in HIM-15. See P.L. 97-248 (TEFRA). In addition, MAD applies the following restrictions for new construction:

(1) The total basis of depreciable assets does not exceed the median cost of constructing a hospital as listed in an index acceptable to MAD,

adjusted for New Mexico costs and for inflation in the construction industry from the date of publication to the date the provider is expected to become a MAD provider.

(2) The cost of construction is expected to include only the cost of buildings and fixed equipment.

(3) A reasonable value of land and major movable equipment is added to obtain the value of the entire facility.

[8.311.2.14 NMAC - Rp 8.311.2.14 NMAC, 7/01/2024]

8.311.2.15 OUTPATIENT SERVICES: MAD covers outpatient services which are medically necessary for prevention, diagnosis or rehabilitation as indicated by the condition of an eligible recipient. Services must be furnished within the scope and practice of a professional provider as defined by state laws and regulations.

A. Outpatient covered services: Covered hospital outpatient care includes the use of minor surgery or cast rooms, intravenous infusions, catheter changes, first aid care of injuries, laboratory and radiology services, and diagnostic and therapeutic radiation, including radioactive isotopes. A partial hospitalization program in a general hospital psychiatric unit is considered under outpatient services. See 8.321.5 NMAC, *Outpatient Psychiatric Services and Partial Hospitalization*.

B. Outpatient noncovered services: MAD does not cover the following specific outpatient benefits:

(1) outpatient hospital services not considered medically necessary for the condition of the eligible recipient;

(2) outpatient hospital services that require prior approval for which the approval was not requested except in cases with extenuating circumstances as granted by MAD or its designee;

(3) outpatient hospital services furnished to an individual who was not eligible for MAD services on the date of service;

(4) experimental or investigational procedures, technologies or therapies and the services related to them, including hospitalization, anesthesiology, laboratory tests, and imaging services; see 8.325.6 NMAC, *Experimental or Investigational Procedures or Therapies*;

(5) drugs classified as "ineffective" by the federal food and drug administration;

(6) laboratory specimen handling or mailing charges; and

(7) formal educational or vocational services which relate to traditional academic subjects or training for employment.

C. MCO payment rates: If a provider and an MCO are unable to agree to terms or fail to execute an agreement for any reason, the MCO shall be obliged to pay, and the provider shall accept, one hundred percent of the "applicable reimbursement rate" based on the provider type for services rendered under both emergency and non-emergency situations. The "applicable reimbursement rate" is defined as the rate paid by HCA to the provider participating in medicaid or other medical assistance programs administered by HCA and excludes disproportionate share hospital and medical education payments.

D. Prior authorization: Certain procedures or services performed in outpatient settings can require prior approval from MAD or its designee. Outpatient physical, occupational, and speech therapies services require prior authorization.

E. Reimbursement for outpatient services: Effective November 1, 2010, outpatient hospital services are reimbursed using outpatient prospective payment system (OPPS) rates. The OPPS rules for payment for packaged services, separately reimbursed services are based on the medicare ambulatory payment classification (APC) methodology.

(1) Reimbursement for laboratory services, radiology services, and drug items will not exceed maximum levels established by MAD. Hospitals must identify drugs items purchased at 340B prices.

(2) Services or supplies furnished by a provider under contract or through referral must meet the contract services requirements and be reimbursed based on approved methods. See 8.302.2 NMAC, *Billing For Medicaid Services.*

(3) For critical access hospital providers, the MAD outpatient prospective payment system (OPPS) fee-for-service rate will be set based on the provider's reported cost to charge ratio reported in the provider's most recently filed cost report prior to February 1, 2012.

(4) For services not reimbursed using the outpatient prospective payment system (OPPS) methodology or fee schedule, reimbursement for a MAD fee-for-service provider will be made using the medicare allowable cost method, reducing medicare allowable costs by three percent. An interim rate of payment is established by MAD. A rate of payment for providers not subject to the cost settlement process is also established by MAD to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principals. If the provider is not cost settled, the reimbursement rate will be at the provider's cost to charge ratio reported in the provider's most recently filed cost report prior to February 1, 2012. Otherwise, rates are established after considering available cost to charge ratios, payment levels made by other payers, and MAD payment levels for services of similar cost, complexity and duration.

[8.311.2.15 NMAC - Rp 8.311.2.15 NMAC, 7/01/2024]

8.311.2.16 EMERGENCY ROOM SERVICES: MAD covers emergency room services which are medically necessary for the diagnosis and treatment of medical or surgical emergencies to an eligible recipient and which are within the scope of the

MAD program.

A. Covered emergency services: 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.

B. Retrospective review: An emergency room service may be subject to prepayment or post-payment review. A provider, including an enrolled provider, a non-enrolled provider, a managed care organization provider, or an out of network provider cannot bill an eligible recipient for emergency room services including diagnostic and ancillary services which have been denied due to lack of medical necessity or lack of being an emergency except as specifically allowed by 8.302.2 NMAC, *Billing for Medicaid Services*. When an eligible recipient has identified himself or herself to a provider as a medicaid eligible recipient and is enrolled in a managed care organization, the provider of services must accept and adhere to the provisions of 42 CFR 438 Subpart C Enrollee Rights and Protections which state the administrative and payment responsibilities of a managed care organization and limit the financial responsibilities that can be passed on to an eligible recipient. Payment may be limited to medically necessary diagnostic and treatment services to sufficiently assess the recipient's condition and need for emergency services, the duration of a condition, and available alternatives to emergency room services.

C. Prior authorization: Some services or procedures performed in an emergency room setting need prior approval from MAD or its designee. Procedures that require prior approval in non-emergency settings also require prior approval in emergency settings.

D. Noncovered emergency services: MAD does not cover the following specific emergency services:

(1) diagnostic and other ancillary services which are not considered medically necessary as emergency services;

(2) emergency services furnished to individuals who were not eligible for MAD services on the date of service;

(3) experimental or investigational procedures, technologies or therapies and the services related to them, including hospitalization, anesthesiology, laboratory tests and imaging services; see 8.325.6 NMAC, *Experimental or Investigational Procedures or Therapies*;

(4) drugs classified as "ineffective" by the federal food and drug administration; and

(5) laboratory specimen handling or mailing charges.

E. Reimbursement for emergency room service: An emergency service furnished by an eligible provider is reimbursed as outpatient hospital services. See Subsection D of 8.311.2.15 NMAC, *reimbursement for outpatient services*.

(1) An emergency room service furnished in a DRG-reimbursed hospital in conjunction with an inpatient admission is included with the charges for inpatient care. In this case, a payment for an emergency room service is included in the DRG rate.

(2) A physician's service furnished in an emergency room is not reimbursed to a hospital but may be paid as a professional component of a service. See 8.310.2 NMAC, *Medical Services Providers*.

(3) A service furnished in an urgent care center of a hospital which does not meet the definition of an emergency, may not be submitted as an emergency room service.

[8.311.2.16 NMAC - Rp 8.311.2.16 NMAC, 7/01/2024]

HISTORY OF 8.311.2 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

ISD 310.0200, Hospital Services, filed 1/9/1980.
ISD 310.0200, Hospital Services, filed 12/8/1990.
ISD 310.0200, Hospital Services, filed 12/30/1981.
ISD 310.0200, Hospital Services, filed 4/2/1982.
ISD 310.0200, Hospital Services, filed 7/8/1982.
ISD Rule 310.0200, Hospital Services, filed 4/5/1983.
ISD Rule 310.0200, Hospital Services, filed 2/15/1984.
ISD Rule 310.0200, Hospital Services, filed 4/26/1984.
ISD Rule 310.0200, Hospital Services, filed 2/21/1986.
MAD Rule 310.02, Hospital Services, filed 12/1/1987.
MAD Rule 310.02, Hospital Services, filed 4/27/1988.
MAD Rule 310.02, Hospital Services, filed 5/23/1988.
MAD Rule 310.02, Hospital Services, filed 8/18/1988.
MAD Rule 310.02, Hospital Services, filed 3/20/1989.
MAD Rule 310.02, Hospital Services, filed 7/2/1990.
MAD Rule 310.02, Hospital Services, filed 3/27/1992.
MAD Rule 310.02, Hospital Services, filed 4/21/1992.
MAD Rule 310.02, Hospital Services, filed 5/1/1992.
MAD Rule 310.02, Hospital Services, filed 7/14/1993.
MAD Rule 310.02, Hospital Services, filed 3/10/1994.
MAD Rule 310.02, Hospital Services, filed 6/15/1994.
MAD Rule 310.02, Hospital Services, filed 12/8/1994.

History of Repealed Material:

MAD Rule 310.02, Hospital Services,

filed 12/8/1994 - Repealed effective 2/1/1995.
8 NMAC 4.MAD.721, Hospital Services, filed 1/18/1995 - Repealed effective 1/1/2009.
8.311.2 NMAC, Hospital Services, filed 12/24/2008 - Repealed effective 7/1/2024.

Other: 8.311.2 NMAC, Hospital Services, filed 12/24/2008 Replaced by 8.311.2 NMAC, Hospital Services effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 313 LONG TERM CARE SERVICES - INTERMEDIATE CARE FACILITIES
PART 2 INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

8.313.2.1 ISSUING AGENCY: New Mexico Health Care Authority, Medical Assistance Division.
[8.313.2.1 NMAC - Rp 8.313.2.1 NMAC, 7/1/2024]

8.313.2.2 SCOPE: This rule applies to the general public.
[8.313.2.2 NMAC - Rp 8.313.2.2 NMAC, 7/1/2024]

8.313.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.313.2.3 NMAC - Rp 8.313.2.3 NMAC, 7/1/2024]

8.313.2.4 DURATION: Permanent
[8.313.2.4 NMAC - Rp 8.313.2.4 NMAC, 7/1/2024]

8.313.2.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.313.2.5 NMAC - Rp 8.313.2.5 NMAC, 7/1/2024]

8.313.2.6 OBJECTIVE: The objective of these regulations is to govern the service portion of the New Mexico medicaid and medical assistance programs. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.313.2.6 NMAC - Rp 8.313.2.6 NMAC, 7/1/2024]

8.313.2.7 DEFINITIONS: [**RESERVED**]

8.313.2.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of HCA/MAD program eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.313.2.8 NMAC - Rp 8.313.2.8 NMAC, 7/1/2024]

8.313.2.9 INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to recipients, including services furnished by intermediate care facilities for the mentally retarded 42 CFR 440.150. This section describes eligible providers, covered services, service restrictions, personal fund accounts, and general reimbursement methodology.
[8.313.2.9 NMAC - Rp 8.313.2.9 NMAC, 7/1/2024]

8.313.2.10 ELIGIBLE PROVIDERS:

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

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

(2) the ICF-MR must comply with 8.313.2.17 NMAC, *Recipient Personal Fund Accounts*; and

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

B. Once enrolled, providers receive instruction on how to access medicaid and other medical assistance provider program policies, billing instructions, utilization review instructions, and other pertinent material. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements. To be eligible for medical assistance program reimbursement, providers are bound by the provisions of the provider participation agreement.
[8.313.2.10 NMAC - Rp 8.313.2.10 NMAC, 7/1/2024]

8.313.2.11 APPEALS PROCESS FOR DENIAL, TERMINATION OR NON-RENEWAL OF PARTICIPATION: See Section MAD-967.5, *Appeals for Denial, Termination, or Non-Renewal of Provider Participation*.
[8.313.2.11 NMAC - Rp 8.313.2.11 NMAC, 7/1/2024]

8.313.2.12 SANCTIONS AND PENALTIES: See Section MAD-967, *Sanctions for Non-Compliance* and Section MAD-968, *Intermediate Remedies*.
[8.313.2.12 NMAC - Rp 8.313.2.12 NMAC, 7/1/2024]

8.313.2.13 PROVIDER RESPONSIBILITIES:

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

B. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Providers must maintain all medical or business records as necessary to fully disclose the type and extent of services provided to recipients. See Section MAD-701, *General Provider Policies*.
[8.313.2.13 NMAC - Rp 8.313.2.13 NMAC, 7/1/2024]

8.313.2.14 REQUIRED SERVICES: Medicaid does not reimburse ICFs-MR for furnishing services, unless they provide at least the following, see 42 CFR 483.440(a):

A. room and board;

B. continuous active treatment program, including aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that are directed towards the following:

(1) acquisition of the behaviors necessary for the recipient to function with as much self determination and independence as possible; and

(2) prevention or deceleration of regression or loss of current functional status.

C. personal assistance services 24 hours a day, seven days a week; personal assistance services are those services, other than professional nursing services, which may be needed by an individual because of age, infirmity, physical or mental limitations, or dependence in accomplishing the activities of daily living.
[8.313.2.14 NMAC - Rp 8.313.2.14 NMAC, 7/1/2024]

8.313.2.15 COVERED SERVICES: Medicaid covers the costs of ICF-MR services identified as allowable. See 8.313.3 NMAC, *Cost Related Reimbursement of Intermediate Care Facilities for the Mentally Retarded*, Section III.G. Pharmacy services furnished in the ICF-MR are reimbursed separately and are subject to specific requirements. See Section MAD-753, *Pharmacy Services*.
[8.313.2.15 NMAC - Rp 8.313.2.15 NMAC, 7/1/2024]

8.313.2.16 NONCOVERED SERVICES:

A. Medicaid does not cover the costs of ICF-MR services that are not allowable. See 8.313.3 NMAC, *Cost Related Reimbursement of Intermediate Care Facilities for the Mentally Retarded*.

B. Medicaid does not pay for residents with a primary diagnosis of mental retardation who are receiving care in a general nursing facility setting. Coverage of these residents is included only when they are residing in an ICF-MR facility or in a nursing facility when they have a medical condition which by and of itself would justify NF care.
[8.313.2.16 NMAC - Rp 8.313.2.16 NMAC, 7/1/2024]

8.313.2.17 RECIPIENT PERSONAL FUND ACCOUNTS:

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

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

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

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

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

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

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

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

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

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

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

(4) facilities must ensure that there is a full,

complete and separate accounting, based on generally accepted accounting principles, of each resident's personal funds entrusted to facilities on the resident's behalf.

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

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

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

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

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

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

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

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

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

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

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

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

(2) To use the petty cash fund, the following procedures should be established:

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

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

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

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

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

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

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

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

(a) count money on hand; and

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

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

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

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

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

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

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

G. Retention of records: All account records other

than financial and statistical cost reports must be retained until after an audit is complete or six years, whichever is greater. For details on retention of financial and statistical cost reports, see Subsection D of 8.313.3.12 NMAC *Retention of Records*.

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

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

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

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

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

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

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

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

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

(2) The HCA or its designee can complete a thorough audit of residents' personal fund accounts at HCA's discretion. [8.313.2.17 NMAC - Rp 8.313.2.17 NMAC, 7/1/2024]

8.313.2.18 LEVEL OF CARE DETERMINATION: Medical necessity, level of care or length of stay determinations, and on-site review activities are carried out in accordance with the MAD utilization review policy and procedures, authorized under Title XIX of the Social Security Act. See 8.350.3 NMAC, *Abstract Submission for Level of Care Determinations*. [8.313.2.18 NMAC - Rp 8.313.2.18 NMAC, 7/1/2024]

8.313.2.19 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All HCA/MAD program services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

A. Prior authorization: Certain procedures or services can require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior authorization of services does not guarantee that individuals are eligible for HCA/MAD programs. Providers must verify that individuals are eligible for HCA/MAD programs at the time services are furnished and determine if HCA/MAD program recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior authorization request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration Of Utilization Review Decisions*. [8.313.2.19 NMAC - Rp 8.313.2.19 NMAC, 7/1/2024]

8.313.2.20 RESERVE BED DAYS: Medicaid pays to hold or reserve a bed for a resident of an ICF-MR for the following reasons: 1) to allow the resident to make home and community visits, e.g., vacations; 2) to adjust to a new living environment; or 3) for hospitalizations.

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

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

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

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

(a) the resident's name;

(b) social security number;

(c) requested approval dates;

(d) copy of the discharge plan;

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

(f) written physician order for trial placement.

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

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

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

[8.313.2.20 NMAC - Rp 8.313.2.20 NMAC, 7/1/2024]

8.313.2.21 Reimbursement: Intermediate care providers must submit claims for reimbursement on the long term care turn around documents (TAD) or its successor. See Section MAD-702, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing, and claims processing.

A. MAD reimburses ICF-MR the lower of the following:

(1) the provider's billed charges; or

(2) the prospective rate as constrained by the ceilings established by MAD. See 8.313.3 NMAC, *Cost Related Reimbursement of Intermediate Care Facilities for the Mentally Retarded*.

B. Reimbursement limitations: Medicaid pays only those ICF-MRs which meet the conditions for participation, specified in this section. Payments to ICF-MRs for services are limited to those services which are included as allowable service costs under the approved state plan. All claims for payment submitted to MAD are subject to utilization review and control.

C. Reimbursement methodology: See 8.313.3 NMAC, *Cost Related Reimbursement of Intermediate Care Facilities for the Mentally Retarded*.

[8.313.2.21 NMAC - Rp 8.313.2.21 NMAC, 7/1/2024]

HISTORY OF 8.313.2 NMAC:
The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:
ISD 310.0300, Care In Skilled Nursing Facility And Intermediate Care Facility, 2/27/1980.
SP-004.1401, Utilization Review Plan for Intermediate Care Facilities, 6/10/1981.
MAD Rule 310.03, Care In Skilled Nursing Facility And Intermediate Care Facility, 12/1/1987.
MAD Rule 310.03, Care In Skilled Nursing Facility And Intermediate Care Facility, 1/6/1988.
MAD Rule 310.03, Care In Skilled Nursing Facility And Intermediate Care Facility For The Mentally Retarded, 3/27/1992.

History of Repealed Material:
8.313.2 NMAC, Intermediate Care Facilities For The Mentally Retarded, filed 10/17/2000 Repealed effective 7/1/2024.

Other: 8.313.2 NMAC, Intermediate Care Facilities For The Mentally Retarded, filed 10/17/2000 Replaced by 8.313.2 NMAC, Intermediate Care Facilities For The Mentally Retarded, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 313 LONG TERM CARE SERVICES - INTERMEDIATE CARE FACILITIES
PART 3 COST RELATED REIMBURSEMENT OF ICF-MR FACILITIES

8.313.3.1 ISSUING AGENCY: Health Care Authority, Medical Assistance Division.
[8.313.3.1 NMAC - Rp 8.313.3.1 NMAC, 7/1/2024]

8.313.3.2 SCOPE: This rule applies to the general public.
[8.313.3.2 NMAC - Rp 8.313.3.2 NMAC, 7/1/2024]

8.313.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.313.3.3 NMAC - Rp 8.313.3.3 NMAC, 7/1/2024]

8.313.3.4 DURATION: Permanent.
[8.313.3.4 NMAC - Rp 8.313.3.4 NMAC, 7/1/2024]

8.313.3.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.313.3.5 NMAC - Rp 8.313.3.5 NMAC, 7/1/2024]

8.313.3.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid

program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement. [8.313.3.6 NMAC - Rp 8.313.3.6 NMAC, 7/1/2024]

8.313.3.7 DEFINITIONS:

A. Accrual basis of accounting: Under the accrual basis of accounting, revenue is recorded in the period when it is earned, regardless of when it is collected. The expenditures for expense and asset items are recorded in the period in which they are incurred, regardless of when they are paid.

B. Cash basis of accounting: Under the cash basis of accounting, revenues are recognized only when cash is received and expenditures for expense and asset items are not recorded until cash is disbursed for them.

C. Governmental institution: A provider of services owned and operated by a federal, state or local governmental agency.

D. Allocable costs: An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with cost responsibilities, benefits received, or other identifiable measure of application or consumption.

E. Applicable credits: Those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. Typical examples of such transactions are: purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of over-payments or erroneous charges; and other income items which serve to reduce costs. In some instances, the amounts received from the federal government to finance hospital activities or service operations should be treated as applicable credits.

F. Charges: The regular rates established by the provider for services rendered to both medicaid recipients and to other paying patients whether inpatient or outpatient. The rate billed to the HCA shall be the usual and customary rate charged to all patients.

G. Cost finding: A determination of the cost of services by the use of informal procedures, i.e., without employing the regular processes of cost accounting on a continuous or formal basis. It is the determination of the cost of an operation by the allocation of direct costs and the proration of indirect costs.

H. Cost center: A division, department, or subdivision thereof, a group of services or employees or both, or any other unit or type of activity into which functions of an institution are divided for purposes of cost assignment and allocations.

I. General service cost centers: Those cost centers which are operated for the benefit of other general service areas as well as special or patient care departments. Examples of these are: housekeeping, laundry, dietary, operation of plant, maintenance of plant, etc. Costs incurred for these cost center are allocated to other cost centers on the basis of services rendered.

J. Special service cost centers: Commonly referred to as ancillary cost center. Such centers usually provide direct identifiable services to individual patients, and include departments such as the physical therapy and supply departments.

K. Inpatient cost centers: Cost centers established to accumulate costs applicable to providing routine and ancillary services to inpatients for the purposes of cost assignment and allocation.

L. Provider: The entity responsible for the provision of services. The provider must have entered into a valid agreement with the medicaid program for the provision of such services.

M. Facility: The actual physical structure in which services are provided.

N. Owner: The entity holding legal title to the facility. [8.313.3.7 NMAC - Rp 8.313.3.7 NMAC, 7/1/2024]

8.313.3.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans. [8.313.3.8 NMAC - Rp 8.313.3.8 NMAC, 7/1/2024]

8.313.3.9 COST RELATED REIMBURSEMENT OF ICF-MR FACILITIES: The New Mexico title XIX program makes reimbursement for appropriately licensed and certified intermediate care facilities for the mentally retarded as outlined in this material. [8.313.3.9 NMAC - Rp 8.313.3.9 NMAC, 7/1/2024]

8.313.3.10 GENERAL REIMBURSEMENT POLICY: The HCA will reimbursement ICF/MR facilities the lower of the following, effective September 1, 1990:

A. billed charges;

B. the prospective rate as constrained by the ceilings established by the HCA as described in this plan. [8.313.3.10 NMAC - Rp 8.313.3.10 NMAC, 7/1/2024]

8.313.3.11 DETERMINATION OF ACTUAL, ALLOWABLE AND REASONABLE COSTS AND SETTING OF PROSPECTIVE RATES:

A. Adequate cost data:

(1) Providers receiving payment on the basis of reimbursable cost must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data on this basis will be acceptable, subject to appropriate treatment of capital expenditures.

(2) The cost finding method to be used by ICF-MR providers will be the step-down method. This method recognizes that services rendered by certain non-revenue producing departments or centers are utilized by certain other non-revenue producing centers. All cost of non-revenue producing centers are allocated to all centers which they serve, regardless of whether or not these centers produce revenue. The cost of the non-revenue producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the non-revenue producing center, that center will be considered "closed" and no further costs will be apportioned to it. This applies even though it may have received some service from a center whose cost is apportioned later. Generally when two centers render services to an equal number, that center which has the greater amount of expense will be allocated first.

B. Reporting year: For the purpose of determining a prospective per diem rate related to cost for ICF-MR services, the reporting year is the provider's fiscal year. The provider will submit a cost report each fiscal year.

C. Cost reporting:

(1) At the end of each fiscal year the provider will provide to the state agency or its audit agent an itemized list of allowable costs (financial and statistical report) on the N.M. title XIX cost reporting form. This cost report must be submitted on an annual basis to MAD or its designee within the time frames specified by medicare. ICFs-MR will not be granted an extension to the cost report filing time frames. Failure to file a cost report within the specified time frames will result in suspension of title XIX payments.

(2) In the case of a change of ownership, the previous provider must file a final cost report as of the date of the change of ownership in accordance with reporting requirements specified in this plan. The HCA will withhold the last two month's payment to the previous provider as security against any outstanding obligations to the HCA. The provider must notify the HCA 60 days prior to any change of ownership.

D. Retention of records:

(1) Each ICF-MR provider shall maintain financial and statistical records of the period covered by a cost report for a period of not less than four years following the date of submittal of the cost report to the state agency. These records must be accurate and in sufficient detail to substantiate the cost data reported. The provider shall make such records available upon demand to representatives of the state agency, the state audit agent, or the department of health and human services.

(2) The state agency or its audit agent will retain all cost reports submitted by providers for a period of not less than three years following the date of final settlement of such report.

E. Audits: Audits will be performed in accordance with 42 CFR 447.202.

(1) Desk audit: Each cost report submitted will be subject to a comprehensive desk audit by the state audit agent. This desk audit is for the purpose of analyzing the cost report. After each desk audit is performed, the audit agent will submit a complete report of the desk review to the state agency.

(2) Field audit: Field audits will be performed on all providers at least once every three years. The purpose of the field audit of the provider's financial and statistical records is to verify that the data submitted on the cost report are in fact accurate, complete and reasonable. The field audits are conducted in accordance with generally accepted auditing standards and of sufficient scope to determine that only proper items of cost applicable to the service furnished were included in the provider's calculation of its cost. The field audit will also determine whether the expenses attributable to such proper items of cost were reasonably and accurately determined. After each field audit is performed, the audit agent will submit a complete report of the audit to the state agency. This report will meet generally accepted auditing standards and shall declare the auditor's opinion as to whether, in all material respects, the costs reported by the provider are allowable, accurate and reasonable in accordance with the state plan. These audit reports will be retained by the state agency for a period of not less than three years from the date of final settlement of such reports.

F. Overpayments: All overpayments found in audits will be accounted for on the HCFA 64 report to HHS no later than the second quarter following the quarter in which found.

G. Allowable costs: The following identifies costs that are allowable in the determination of a provider's actual, allowable and reasonable costs. All costs are subject to all other terms stated in the medicare provider reimbursement manual (PRM 15-1) that are not modified by these regulations.

(1) Cost of meeting certification standards: These will include all items of expense that the provider must incur under:

(a) 42 CFR 442;

(b) Sections 1861(j) and 1902(a)(28) of the Social Security Act;

(c) standards included in 42 CFR 431.610;

(d) cost incurred to meet requirements for licensing under state law which are necessary to provide ICF-MR service.

(2) Costs of routine services: Allowable costs shall include all items of expense that providers incur to provide routine services, known as operating costs. Operating costs include such things as:

(a) regular room;

(b) dietary and nursing services;

(c) medical and surgical supplies (including but not limited to syringes, catheters, ileostomy, and colostomy supplies);

(d) use of equipment and facilities;

(e) general services, including administration of oxygen and related medications, hand feeding, incontinency care, tray service and enemas;

(f) items furnished routinely and relatively uniform to all patients, such as patient gowns, water pitchers, basins and bed pans;

(g) items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities, such as alcohol and body rubs, applicators, cotton balls, bandaids, laxatives and fecal softeners, aspirin, antacids, OTC ointments, and tongue depressors;

(h) items which are used by individual patients but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, oxygen administration equipment, and other durable equipment;

(i) special dietary supplements used for tube feeding or oral feeding even if prescribed by a physician;

(j) laundry services other than for personal clothing;

(k) oxygen for emergency use--the HCA will allow two options for the purchase of oxygen for patients for whom the attending physician prescribes oxygen administration on a regular or on-going basis:

(i) the provider may purchase the oxygen and include it as a reimbursable cost in its cost report; this is the same as the method of reimbursement for oxygen administration equipment; or

(ii) the HCA will make payment directly to the medical equipment provider in accordance with procedures outlined in medical assistance manual Section 754, medical supplies, and subject to the limitations on rental payments contained in that section.

(l) all services delivered in relation to active treatment, such as physical therapy, occupational therapy, speech therapy, psychology services, recreational therapy, etc.;

(m) managerial, administrative, professional and other services related to the providers operation and rendered in connection with patient care.

(3) Facility cost, for the purpose of specific limitations included in this plan, include only depreciation, lease costs, and long term interest.

(a) Depreciation is the systematic distribution of the cost or other basis of tangible assets, less salvage value, over the estimated life of the assets.

(i) The basis for depreciation is the historical cost of purchased assets or the fair market value at the time of donation for donated assets.

(ii) Historical cost is the actual cost incurred in acquiring and preparing an asset for use.

(iii) Fair market value is the price for which an asset would have been purchased on the date of acquisition in an arms-length transaction between an informed buyer and seller, neither being under any compulsion to buy or sell. Fair market value shall be determined by a qualified appraiser who is a registered member of the American institute of real estate appraisers (MAI) and who is acceptable to the HCA

(iv) In determining the historical cost of assets where an on-going facility is purchased, the provisions of medicare provider reimbursement manual PRM 15-1 will apply.

(v) Depreciation will be calculated using the straight-line method and estimated useful lives approximating the guidelines published in American hospital association useful lives guide.

(b) Long-term interest is the cost incurred for the use of borrowed funds for capital purposes, such as the acquisition of facility, equipment, improvements, etc., where the original term of the loan is more than one year.

(c) Lease term will be considered a minimum of five years for purposes of determining allowable lease costs.

H. Non-allowable costs:

(1) Bad debts, charity, and courtesy allowances: Bad debts on non-title XIX program patients and charity and courtesy allowances shall not be included in allowable costs.

(2) Purchases from related organizations: Cost applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable services, facilities or supplies purchased elsewhere. Providers shall identify such related organizations and costs in the states' cost reports.

(3) Return on equity capital.

(4) Other cost and expense items identified as unallowable in PRM 15-1.

(5) Interest paid on overpayments as per MAD-702, *Billing for Medicaid Services*.

(6) Any civil monetary penalties levied in connection with licensure, certification, or fraud regulations.

[8.313.3.11 NMAC - Rp 8.313.3.11 NMAC, 7/1/2024]

8.313.3.12 ESTABLISHMENT OF PROSPECTIVE PER DIEM RATES: Prospective per diem rates will be established as follows and will be the lower of the amount calculated

using the following formulas, or any applicable ceiling:

A. Base year:

(1) For implementation year one (effective September 1, 1990), the providers base year will be for cost reports filed for base year periods ending no later than June 30, 1990. Since these cost reports will not be audited at the time of implementation, an interim rate will be calculated and once the audited cost report is settled, a final prospective rate will be determined. Retrospective settlements of over or under payments resulting from the use of the interim rate will be made.

(2) Re-basing of the prospective per diem rate will take place every three years. Therefore, the operating years under this plan will be known as year one, year two, and year three. Since re-basing is done every three years, operating year four will again become year one.

(3) Costs incurred, reported, audited or desk reviewed for the provider's last fiscal year which falls in the calendar year prior to year one will be used to re-base the prospective per diem rate. Re-basing costs in excess of one hundred and ten percent of the previous year's reported cost per diem times the index (as described further on in these regulations) will not be recognized for calculation of the base year costs.

B. Inflation factor to recognize economic conditions and trends during the time period covered by the facility's prospective per diem rate. Pursuant to budget availability and at the HCA's discretion, an inflation factor may be used to recognize economic conditions and trends. A notice will be sent out every September informing each provider that:

(1) MBI will or will not be authorized for determining rates for the year; and

(2) the percentage increase if the MBI is authorized;

(3) if utilized, the index used to determine the inflation factor will be the center for medicare and medicaid services (CMS) market basket index (MBI);

(4) each provider's operating costs will be indexed to a mid-year point of February 28 for operating year 1;

(5) if utilized, the inflation factor will be the actual MBI for the previous calendar year.

C. Incentive to reduce increases in cost:

(1) As an incentive to reduce the increases in the administrative and general (A&G) and room and board (R&B) cost center, the HCA will share with the provider the savings below the A&G/R&B ceiling in accordance with the formula described below:

A = [1/2 (B-C)] < $1.00

(2) Where:

A = allowable Incentive per diem

B = A&G/R&B ceiling per diem

C = allowable A&G/R&B per diem from the base year's cost report

D. Cost centers for rate calculation: For the purpose of rate calculation, costs will be grouped into four major cost centers. These are:

(1) direct patient care (DPC)

(2) administration and general (A&G)

(3) room and board (R&B)

(4) facility costs (FC)

E. Case-mix adjustment:

(1) In assuring the prospective reimbursement system addresses the needs of residents of ICF-MR facilities, a case mix adjustment factor will be incorporated into the reimbursement system. The case-mix index (CMI) will be used to adjust the reimbursement levels in the direct patient care cost center. The key objective of the CMI is to link reimbursement to the acuity level of residents in a facility. To accomplish this objective, the HCA utilizes level of care criteria which classify ICF-MR residents into one of three levels, with level I representing the highest level of need. Corresponding to each level of care, the relative values are as follows:

level I 1.077

level II 0.953

level III 0.768

(2) Using these level specific relative values, a provider specific base year CMI will be calculated. The CMI represents the weighted average of the residents' level of care divided by the total number of residents in the facility. The CMI is calculated as follows:

[(A x 1.077)+(B x .953)+(C x .768)]/N = CMI

(3) WHERE:

A = number of level I residents

B = number of level II residents

C = number of level III residents

N = total number of provider's residents

F. Calculation of the prospective per diem rate:

(1) A prospective per diem rate for each of the three levels of ICF-MR classification will be determined for each provider. Payment will be made based on the rate for the level of classification of the recipient.

(2) The provider's direct patient care (DPC) allowable cost will be divided by the provider's CMI to determine the cost at a value of 1.00 for the base year. The adjusted DPC is then multiplied by the relative value of the level of classification to determine the DPC component of the rate. To this, will be added the allowable A & G and R & B amount and the allowable facility cost. The formula for the rates will be as follows:

(3) The formula for year one is: (A1 x

RV) + C1 + D + E = PR (year 1)

(4) The formula for year two is: [(A1 x RV) + C1) x (1 + MBI)] + D + E = PR (year 2)

(5) The formula for year three is: [(A2 x RV) + C2) x (1 + MBI)] + D + E = PR (year 3)

(6) Where:

A = allowable DPC per diem adjusted to a value of 1.00

B = the relative value of the level of classification.

C = allowable A&G and R&B per diem

D = allowable incentive per diem

E = allowable facility cost per diem

MBI = market basket index

PR = prospective rate

RV = the relative value for the level

"1"= the numerical subscript means the date of the data used in the formula; for example, "A1" means the base direct patient care costs established in the base year, while "A2" would refer to the base direct patient care costs adjusted by the MBI.

G. Effective dates of prospective rates: Rates will be effective September 1 of each year for each facility.

H. Calculation of rates for existing providers that do not have actuals as of June 30, 1990, and for new providers entering the program after September 1, 1990. For existing and for new providers entering the program that do not have actuals, the provider's interim prospective per diem rate will become the sum of:

(1) the state wide average patient care cost per diem for each level plus;

(2) the A&G and R&B ceiling per diem plus;

(3) facility cost per diem as determined by using the medicare principles of reimbursement;

(4) after six months of operation or at the provider's fiscal year end, whichever comes later, the provider will submit a completed cost report; this will be audited to determine the actual allowable and reasonable cost for the provider; a final prospective rate will be established at that time, and retroactive settlement will take place.

I. Changes of provider by sale of an existing facility: When a change of ownership occurs, the provider's prospective rate per diem will become the sum of:

(1) the patient care cost per diem for each level, established for the previous owner plus;

(2) the A&G and R&B per diem established for the previous owner; plus

(3) allowable facility costs determined by using the medicare principles of reimbursement.

J. Changes of ownership by lease of an existing facility: When a change of ownership occurs, the provider's prospective per diem rate will become the sum of:

(1) the patient care cost per diem for each level established for the previous owner; plus

(2) the A&G and R&B per diem established for the previous owner; plus

(3) the lower of allowable facility cost or the ceiling on lease cost as described by this plan.

K. Sale/leaseback of and existing facility: When a sale/leaseback of an existing facility occurs, the provider's prospective rate will remain the same as before the transaction.

[8.313.3.12 NMAC - Rp 8.313.3.12 NMAC, 7/1/2024]

8.313.3.13 ESTABLISHMENT OF CEILINGS: Ceilings on the four major cost centers will be established as follow:

A. Direct patient care: No ceiling will be imposed on this cost center.

B. A&G and R&B: The per diem costs for administration and general and for room and board will be grouped together for the establishment of a ceiling. This ceiling will be calculated at one hundred ten percent of the median of allowable costs for the base year, indexed to 12/31 of the base year. The ceiling will then be indexed to the mid-point of year one and set. For years two and three, the ceiling will not be recalculated, but rather will be indexed forward using the appropriate inflation factor described earlier in these regulations.

C. Facility cost:

(1) No ceiling will be imposed on this cost center, except in relation to leases.

(2) Effective for leases executed and binding on both parties on or after September 1, 1990, total allowable lease costs for the entire term of the lease for each facility will be limited to an amount determined by a discounted cash flow technique which will provide the lessor and annual rate of return on the fair market value of the facility equal to one times the average of the rates of interest on special issues of public debt obligations issued to the federal hospital insurance trust fund for the twelve months prior to the date the facility became a provider in the New Mexico medicaid program. The rates of interest for this fund are published in both the federal register and the commerce clearing house (CCH).

(3) The rate of return described above will be exclusive of any escalator clauses contained in the lease. The effect of escalator clauses will be considered at the time they become effective, and the reasonableness of such clauses will be determined by the inflation factor described in Subsection B of 8.313.3.12 NMAC of these regulations.

(4) Any appraisal necessary to determine the fair market value of the facility will be the sole responsibility of the

provider and is not an allowable cost for reimbursement under the program. The appraisals must be conducted by an appraiser certified by a nationally recognized entity, and such appraiser must be familiar with the health care industry, specifically long term care, and must be familiar with geographic area in which the facility is located. Prior to the appraisal taking place, the provider must submit to the HCA the name of the appraiser, a copy of their certification, and a brief description of the appraiser's relevant experience. The use of a particular appraiser is subject to the approval of the HCA.
[8.313.3.13 NMAC - Rp 8.313.3.13 NMAC, 7/1/2024]

8.313.3.14 ADJUSTMENTS TO BASE YEAR COSTS: Since rebasing of the prospective per diem rate will take place every three years, the HCA recognizes that certain circumstances may warrant an adjustment to the base rate. Therefore, the provider may request such an adjustment for the following reasons:

A. Additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation authorities, or applicable law (e.g. minimum staffing requirements, minimum wage change, property tax increases, etc.)

B. Additional costs incurred as a result of uninsurable losses from catastrophic occurrences.

C. Additional costs of approved expansion, remodeling or purchase of equipment.

D. Such additional costs must reach minimum of $5,000 for facilities with 16 or more beds and $1,000 for facilities with 15 or less beds, of incurred cost per year for rebasing to be considered. The provider may request consideration of such rebasing no more than twice in its fiscal year. The provider is encouraged to submit such rebasing requests before the cost is actually incurred if possible. The HCA will approve or disapprove the rebasing request in a timely manner. If the rebasing is approved, the resulting increase in the prospective per diem rate will go into effect:

(1) beginning with the month the cost was actually incurred if prior approval was obtained, or

(2) no later than 30 days from the date of receipt of the request if retroactive approval was obtained. At no time will rebasing in excess of any applicable ceilings be allowed.
[8.313.3.14 NMAC - Rp 8.313.3.14 NMAC, 7/1/2024]

8.313.3.15 RESERVE BED DAYS: Reserve bed days will be paid using the provider's level III rate.
[8.313.3.15 NMAC - Rp 8.313.3.15 NMAC, 7/1/2024]

8.313.3.16 CAREGIVERS CRIMINAL HISTORY SCREENING: The MAD will reimburse providers for the medicaid portion of the billed amount that providers paid to the New Mexico department of health (DOH). The following is the billing format.

A. Each ICF-MR will pay DOH by check according to DOH regulations.

B. A copy of the check(s) that the ICF-MR sent to DOH will be submitted to medicaid for payment on a quarterly basis on a medicaid reimbursement voucher (available at MAD or at MAD's designee).

C. Medicaid will only be responsible for the medicaid portion of the billed amount.

D. There will be a one-time charge to medicaid for fingerprinting equipment. Ongoing supplies, such as ink, rubber gloves, and other supplies, will be accounted for on the provider's cost report.
[8.313.3.16 NMAC - Rp 8.313.3.16 NMAC, 7/1/2024]

8.313.3.17 RECONSIDERATION PROCEDURES FOR BASE YEAR DETERMINATIONS

A. A provider who is dissatisfied with the base year rate determination or the final settlement (in the case of a change of ownership) may request a reconsideration of the determination by addressing a request for reconsideration to: Director, Medical Assistance Division, P.O. Box 2348, Santa Fe, NM 87504

B. The filing of a request for reconsideration will not affect the imposition of the determination.

C. A request for reconsideration, to be timely, must be filed with or received by the medical assistance division no later than 30 days after the date of the determination notice to the provider.

D. The written request for reconsideration must identify each point on which it takes issue with the audit agent and must include all documentation, citation of HCA, and argument on which the request is based. Any point not raised in the original filed request may not be raised later.

E. The medical assistance division will submit copies of the request and supporting material to the audit agent. A copy of the transmittal letter to the audit agent will be sent to the provider. A written response from the audit agent must be filed with or received by the medical assistance division no later than 30 days after the date of the transmittal letter.

F. The medical assistance division will submit copies of the audit agent's response and supporting material to the provider. A copy of the transmittal letter to the provider will be sent to the audit agent. Both parties may then come up with additional submittals on the point(s) at issue. Such follow-up submittals must be filed with or received by the medical assistance division no later than 15 days after the date of the transmittal letter to the provider.

G. The request for reconsideration and supporting materials, the response and supporting materials, and any additional submittal will be delivered by the medical assistance division director to the secretary, or their designee, within five days after the closing date for final submittals.

H. The secretary, or their designee, may secure all

information and call on all expertise they believe necessary to decide the issues.

I. The secretary, or their designee, will make a determination on each point at issue, with written findings and will mail a copy of the determinations to each party within 30 days of the delivery of the material to him. The secretary's determinations on appeals will be made in accordance with the applicable provisions of the plan. The secretary's decision will be final and changes to the original determination will be implemented pursuant to that decision.
[8.313.3.17 NMAC - Rp 8.313.3.17 NMAC, 7/1/2024]

8.313.3.18 PUBLIC DISCLOSURE OF COST REPORTS

A. Provider's cost reports submitted by participating providers as a basis for reimbursement as required by law are available to the public upon receipt of a written request to the medical assistance division. Information thus disclosed is limited to cost report documents required by social security administration regulations and, in the case of a settled cost report, the notice of program settlement.

B. The request must identify the provider and the specific report(s) requested.

C. The cost for copying will be charged to the requestor.
[8.313.3.18 NMAC - Rp 8.313.3.18 NMAC, 7/1/2024]

8.313.3.19 SEVERABILITY: If any provision of this regulation is held to be invalid, the remainder of the regulations shall not be affected thereby.
[8.313.3.19 NMAC - Rp 8.313.3.19 NMAC, 7/1/2024]

HISTORY OF 8.313.3 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives: SP-004.2400 Section 4, General Program Administration Standards for Skilled Nursing And Intermediate Care Facilities, 3/5/1981.

History of Repealed Material: 8.313.3 NMAC, Cost Related Reimbursement of ICF-MR Facilities, filed 10/18/2000 Repealed effective 7/1/2024.

Other: 8.313.3 NMAC, Cost Related Reimbursement of ICF-MR Facilities, filed 10/18/2000 Replaced by 8.313.3 NMAC, Cost Related Reimbursement of ICF-MR Facilities, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 315 OTHER LONG TERM CARE SERVICES
PART 2 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

8.315.2.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.315.2.1 NMAC - Rp 8.315.2.1 NMAC, 7/1/2024]

8.315.2.2 SCOPE: The rule applies to the general public.
[8.315.2.2 NMAC - Rp 8.315.2.2 NMAC, 7/1/2024]

8.315.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.315.2.3 NMAC - Rp 8.315.2.3 NMAC, 7/1/2024]

8.315.2.4 DURATION: Permanent.
[8.315.2.4 NMAC - Rp 8.315.2.4 NMAC, 7/1/2024]

8.315.2.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.315.2.5 NMAC - Rp 8.315.2.5 NMAC, 7/1/2024]

8.315.2.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.315.2.6 NMAC - Rp 8.315.2.6 NMAC, 7/1/2024]

8.315.2.7 DEFINITIONS: [**RESERVED**]

8.315.2.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.315.2.8 NMAC - Rp 8.315.2.8 NMAC, 7/1/2024]

8.315.2.9 PACE PROGRAM SERVICES: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients, including services furnished in nursing facilities. To help New Mexico recipients receive necessary services, the New Mexico medical assistance division (MAD) pays for capitated and community-based services through the PACE program. This project provides a complete package of acute, long term care, personal care and social services to a frail population that meets nursing facility clinical criteria. See Section 9412(b) of the federal Omnibus Budget Reconciliation Act of 1986

and Section 1915(a) of the Social Security Act. This part describes the following: eligible providers, services for recipients who are nursing home eligible, covered services, service limitations, and reimbursement methodology.
[8.315.2.9 NMAC - Rp 8.315.2.9 NMAC, 7/1/2024]

8.315.2.10 ELIGIBLE PROVIDERS:

A. The eligible provider will have a professional services agreement (PSA) with the HCA. The provider will also meet the following conditions:

(1) be licensed and certified by the licensing and certification bureau of the department of health (DOH) to meet conditions as a diagnostic and treatment center;

(2) participate in the MAD utilization review process and agree to operate in accordance with all policies and procedures of that system; and

(3) meet and comply with the centers for medicare and medicaid services (CMS) requirements for full provider status for PACE organizations.

B. Once enrolled, the provider will receive a packet of information, including medicaid program policies, utilization review instructions, and other pertinent material from MAD. The provider is responsible for ensuring receipt of these materials and for updating as new materials are received from MAD.
[8.315.2.10 NMAC - Rp 8.315.2.10 NMAC, 7/1/2024]

8.315.2.11 PROVIDER RESPONSIBILITIES:

A. The provider who furnishes services to medicaid recipients will comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. The provider will verify that individuals are eligible for medicaid, medicare, or other health insurance at the time services are furnished. The provider will verify whether or not an individual is self-pay at the time services are provided. The provider will maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients. See 8.302.1 NMAC, *General Provider Policies*. The provider will provide the coordination which will enable the client to utilize PACE as the single source for primary care. This will assist the enrollee in the coordination of care by specialists.

B. Outreach and marketing: The provider will have a written plan which accomplishes the following outreach and marketing objectives.

(1) Strategies of how prospective participants are provided adequate program descriptions.

(a) The program descriptions shall be written in a culturally competent format at a language level understandable by the participant (sixth grade). The format should be sensitive to the culture and language common to the service area.

(b) Program descriptions should include the services available through the program. The services include, but are not limited to, the following: enrollment and disenrollment, procedures to access services, after hours call-in system, provisions for emergency treatment, restrictions against using medical providers or services not authorized by the interdisciplinary team, and any other information necessary for prospective participants to make informed decisions about enrollment. Prior to enrollment, each participant will be informed of what individualized initial assessment and treatment plan has been developed by the interdisciplinary team.

(2) Development of outreach and enrollment materials (including marketing brochures, enrollment agreements, website and disenrollment forms). These materials should be submitted in draft form to MAD for approval prior to publication. Distribution prior to approval is prohibited.

(3) Submit an active and ongoing marketing plan, with measurable enrollment objectives and a system for tracking its effectiveness. The plan shall also include, but not be limited to, the sequence and timing of promotional and enrollment activities and the resources needed for implementation.

(4) Ensure that prohibited marketing activities are not conducted by its employees or its agents. Prohibited practices are:

(a) discrimination of any kind while maintaining the PACE program requirements;

(b) statements or activities that could mislead or confuse potential participants, or misrepresent the contractor, CMS, or the state medicaid agency;

(c) inducing enrollment through gifts or payments; the Procurement Code, Sections 13-1-28 through 13-1-199 NMSA 1978, imposes civil and misdemeanor criminal penalties for its violation; in addition, the New Mexico criminal statutes impose felony penalties for bribes, gratuities and kickbacks; and

(d) subcontracting outreach efforts to individuals or organizations whose sole responsibility involves direct contact with elderly to solicit enrollment.
[8.315.2.11 NMAC - Rp 8.315.2.11 NMAC, 7/1/2024]

8.315.2.12 ELIGIBLE RECIPIENTS: Medicaid recipients who meet the eligibility requirements as stated in the medical assistance division eligibility manual may be eligible to participate in the PACE program.
[8.315.2.12 NMAC - Rp 8.315.2.12 NMAC, 7/1/2024]

8.315.2.13 COVERED SERVICES: The PACE program is a partially capitated, community-based service program. The PACE program will ensure access to a

comprehensive benefit package of services to a frail population that meets nursing facility clinical criteria. The provider will provide all medicaid services that are included in a capitated rate. Medicare covered services will be reimbursed through a medicare capitated rate. The provider will provide medicare-eligible PACE participants with all medicare services that are included in the medicare capitated rate. Effective Janaury 1, 2006, upon the implementation of medicare part D prescription drug coverage, pharmacy costs for PACE medicare beneficiaries are covered by the medicare capitated rate. Pharmacy costs for medicaid only recipients would be covered by the medicaid only capitated rate.

A. Adult day health center: The focal point for coordination and provision of the majority of the PACE program services is the adult day health center. The adult day health center will include a primary care clinic and areas for therapeutic recreation, restorative therapies, socialization, personal care and dining. The center shall include the following areas:

(1) examination room(s);

(2) treatment room(s);

(3) therapy room(s);

(4) dining room(s);

(5) activity room(s);

(6) kitchen;

(7) bathroom(s);

(8) personal care room(s);

(9) administrative office(s);

(10) counseling office(s);

(11) pharmacy/ medication room; and

(12) laboratory;

B. Interdisciplinary team: The interdisciplinary team is a critical element of the PACE program. The ongoing process of service delivery in this model requires the team to identify participant problems, determine appropriate treatment objectives, select interventions and evaluate efficiencies of care on an individual participant basis. The interdisciplinary team is composed of, but not limited to, the following members: Primary care physician, nurse, dietician, social worker, physical therapist, occupational therapist, speech therapist, recreational therapist or coordinator, day health center supervisor, home care liaison, health workers/aides, and drivers. Some of the interdisciplinary team members may be project staff and some may be contracted positions. All members must meet applicable state licensing and certification requirements and provide direct care and services appropriate to participant need.

C. Benefit package: The benefit package includes the following:

(1) a service delivery system that ensures prompt access to all covered services, including referral protocols, approved by the interdisciplinary team;

(2) access to medical care and other services, as applicable, 24 hours per day, seven days a week, 365 days per year; all care and services shall be available and shall be provided at such times and places, including the participants home or elsewhere, as are necessary and practical;

(3) access to an acute and comprehensive benefit package of services, including, but not limited to:

(a) interdisciplinary assessment and treatment planning;

(b) social work services;

(c) nutritional counseling;

(d) recreational therapy;

(e) meals;

(f) restorative therapies, including physical therapy, occupational therapy and speech therapy;

(g) home care (personal care, nursing care and disposable medical supplies), see 8.325.9 NMAC, *Home Health Services*;

(h) transportation, see 8.324.7 NMAC, *Transportation Services and Lodging*;

(i) drugs and biologicals; effective January 1, 2006, pharmacy costs are reimbursed by medicare for medicare beneficiaries; pharmacy costs for medicaid-only recipients are reimbursed by medicaid through the medicaid-only capitated rate; see 8.324.4 NMAC, *Pharmacy Services*, and Subsection D of 8.310.2.12 NMAC, *Medical Services Providers*;

(j) prosthetics, medical supplies and durable medical equipment, corrective vision devices such as eyeglasses and lenses, hearing aids, dentures and repairs and maintenance for these items; see 8.324.8 NMAC, *Prosthetics and Orthotics*; 8.310.6 NMAC, *Vision Care Services*; 8.324.6 NMAC, *Hearing Aids and Related Evaluations*; 8.310.7 NMAC, *Dental Services*; 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies*;

(k) behavioral health services, 8.310.8 NMAC, *Mental Health Professional Services* and 8.315.3 NMAC, *Psychosocial Rehabilitation Services*;

(l) nursing facility services which include, but are not limited to, the following: semi-private room and board, physician and skilled nursing services, custodial care, personal care and assistance, biologicals and drugs, physical, speech, occupational and recreational therapies, if necessary, social services, and medical supplies and appliances, see 8.312.2 NMAC, *Nursing Facilities*; 8.311.4 NMAC, *Outpatient Psychiatric Services and Partial Hospitalization*; 8.325.8 NMAC, *Rehabilitation Service Providers*; 8.324.4 NMAC, *Pharmacy Services*; Subsection D of 8.310.2.12 NMAC, *Medical Services Providers*; 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies*; and

(m) urgent care services.

(4) coordinating access for the following services:

(a) primary care services including physician and nursing services;

(b) medical specialty services, including but not limited to: anesthesiology, audiology, cardiology, dentistry, dermatology, gastroenterology, gynecology, internal medicine, nephrology, neurosurgery, oncology, ophthalmology, oral surgery, orthopedic surgery, otorhinolaryngology, plastic surgery, pharmacy consulting services, podiatry, psychiatry, pulmonary disease, radiology, rheumatology, surgery, thoracic and vascular surgery, urology; see 8.301.2 NMAC, *General Benefit Description*; 8.310.2 NMAC, *Medical Services Providers*; 8.311.2 NMAC, *Hospital Services*; 8.310.5 NMAC, *Anesthesia Services*; 8.324.6 NMAC, *Hearing Aids and Related Evaluations*; 8.310.7 NMAC, *Dental Services*; and 8.310.6 NMAC, *Vision Care Services*;

(c) laboratory and x-rays and other diagnostic procedures; see 8.324.2 NMAC, *Laboratory Services*;

(d) acute inpatient services, including but not limited to, the following: ambulance, emergency room care and treatment room services, semi-private room and board, general medical and nursing services, medical surgical/ intensive care/coronary care unit as necessary, laboratory tests, x-rays and other diagnostic procedures, drugs and biologicals, blood and blood derivatives, surgical care, including the use of anesthesia, use of oxygen, physical, speech, occupational, and respiratory therapies, and social services; see 8.301.2 NMAC, *General Benefit Description*; 8.324.8 NMAC, *Prosthetics and Orthotics*; 8.324.10 NMAC, *Ambulatory Surgical Center Services*; and 8.310.5 NMAC, *Anesthesia Services*; 8.324.2 NMAC, *Laboratory Services*; 8.324.4 NMAC, *Pharmacy Services*; Subsection D of 8.310.2.12 NMAC, *Medical Services Providers*; 8.325.8 NMAC, *Rehabilitation Service Providers*; and

(e) hospital emergency room services.

(5) in-area emergency care; all medicaid reimbursable emergency services included in the capitated rate will be reimbursed by the PACE program to a non-affiliated provider when these services are rendered within the PACE program geographic service area; these emergency services will be reimbursed by the PACE program only until such time as the participant's condition permits travel to the nearest PACE program-affiliated facility;

(6) out-of-area emergency care that is provided in, or en route to, a hospital or hospital emergency room, in a clinic, or physician's office, or any other site outside of the PACE program service area; covered services included in the capitation rate will be paid by the PACE program when rendered in and out-of-area medical emergency, but only until such time as the participants condition permits travel to the nearest PACE program-affiliated facility.

[8.315.2.13 NMAC - Rp 8.315.2.13 NMAC, 7/1/2024]

8.315.2.14 NONCOVERED SERVICES:

A. The following services are not the responsibility of the provider or medicaid:

(1) any medicaid capitated or fee-for-service benefit which has not been authorized by the multidisciplinary team;

(2) in inpatient facilities, private room and private duty nursing, unless medically necessary, and non-medical items for personal convenience, such as telephone charges, radio, or television rental;

(3) cosmetic surgery unless required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy;

(4) experimental medical, surgical or other health procedures or procedures not generally available;

(5) care in a government hospital (veterans administration, federal/state hospital) unless authorized;

(6) service in any hospital for the treatment of chronic, medically uncomplicated drug dependency or alcoholism; and

(7) any services rendered outside of the United States.

B. The participant will be financially responsible for any of the above-mentioned services.

[8.315.2.14 NMAC - Rp 8.315.2.14 NMAC, 7/1/2024]

8.315.2.15 TREATMENT PLANS:

A. Prior to enrollment, an initial assessment and treatment plan for each participant is developed by the interdisciplinary team.

B. Each participant will be reassessed by the interdisciplinary team on a semi-annual basis and informed about a new treatment plan.

C. The enrollee, enrollees family, or representative shall be included in the initial assessment, treatment plan and semi-annual reassessment of the treatment plan.

[8.315.2.15 NMAC - Rp 8.315.2.15 NMAC, 7/1/2024]

8.315.2.16 ENROLLMENT OF PARTICIPANTS:

A. The effective date for the recipient's enrollment in the program is the first day of the calendar month following the signing of the enrollment agreement, if an approved level of care (LOC) and all financial and non-financial eligibility criteria have been approved by the income support division (ISD).

B. The potential participant signs an enrollment agreement which includes, but is not limited to, the following information:

(1) enrollment and disenrollment data that will be

collected and submitted to the HCA, including, but not limited to, the following:

(a) social security number;

(b) health insurance claim number (HIC);

(c) last name, first name, middle initial;

(d) date of birth;

(e) address of current residence;

(f) assigned ISD office address;

(g) medicare number (part A and part B) for medicare beneficiaries;

(h) medicaid number; and

(i) effective date of enrollment in the PACE program;

(2) benefits available, including all medicare and medicaid covered services, and how services are allocated or can be obtained from the PACE program provider, including, but not limited to:

(a) appropriate use of the referral system;

(b) after hours call-in system;

(c) provisions for emergency treatment;

(d) hospitals to be used; and

(e) the restriction that enrollees may not seek services or items from medicaid and medicare providers without authorization from the interdisciplinary team;

(3) participant premiums and procedures for payment, if any; this includes the medical care credit if the participant enters a nursing home;

(4) participant rights, grievance procedures, conditions for enrollment and disenrollment and medicare and medicaid appeal processes;

(5) participants obligation to notify the PACE program provider of a move or absence from the providers service area;

(6) procedures to assure that applicants understand that all medicaid services must be received through the PACE program provider (the "lock-in" provision);

(7) procedures for obtaining emergency services and urgent care;

(8) statements that the PACE program provider has a program agreement with CMS and the state medicaid agency that may be subject to periodic renewal, and that termination of that agreement may result in termination of enrollment in the PACE program; statement that the PACE program provider and the state medicaid agency enter into a contract, which must be periodically renewed, and that failure to renew the contract may result in termination of enrollment in the PACE program;

(9) participants authorization for the disclosure and exchange of information between CMS, its agent, the state medicaid agency and the PACE program provider; and

(10) participant's signature and date.

C. Once the participant signs the enrollment agreement, the participant receives the following:

(1) a copy of the enrollment agreement;

(2) participant/provider contract or evidence of coverage, if this is different from the enrollment agreement;

(3) a PACE program membership card; and

(4) an emergency sticker to be posted in the participants home in case of emergency.

D. The provider will inform the participant and the ISD office when enrollment is completed.

E. Enrollment and services continue unless eligibility of recipient changes or until the participant either voluntarily disenrolls or involuntary disenrollment occurs as described below.

[8.315.2.16 NMAC - Rp 8.315.2.16 NMAC, 7/1/2024]

8.315.2.17 DISENROLLMENT OF PARTICIPANTS: All voluntary and involuntary disenrollments will be documented and available for review by the state medicaid agency. The provider will inform the ISD office when a participant is being disenrolled either voluntarily or involuntarily. Disenrollment is effective by the first day of the second calendar month following the date in which enrollment has changed.

A. Voluntary disenrollment: A participant may begin the process of voluntary disenrollment at any time during the month. The provider shall use the most expedient process allowed by medicaid and medicare procedures while ensuring a coordinated disenrollment date. Until enrollment is terminated, the participants are required to continue using the PACE program services and remain liable for any premiums. The provider shall continue to provide all needed services until the date of termination.

B. Involuntary disenrollment: A participant may be involuntarily disenrolled if the participant:

(1) moves out of the PACE program service area;

(2) is a person with decision-making capacity who consistently does not comply with the individual plan of care and poses a significant risk to self or others;

(3) experiences a breakdown in the physician or team participant relationship such that the PACE program provider's ability to furnish services to either the participant or other participant(s) is seriously impaired;

(4) refuses services or is unwilling to meet conditions of participation as they appear in the enrollment agreement;

(5) refuses to provide accurate financial information, provides false information or illegally transfers assets;

(6) is out of the PACE program provider service area for more than 30 days (unless arrangements have been made with

the PACE program provider);

(7) is enrolled in a PACE program that loses its contracts or licenses which enable it to offer health care services;

(8) ceases to meet the financial or non-financial criteria; and

(9) ceases to meet the level of care (LOC) at any time.

[8.315.2.17 NMAC - Rp 8.315.2.17 NMAC, 7/1/2024]

8.315.2.18 APPROPRIATE REFERRAL FOR OTHER SERVICES:

A. The provider will assist a participant who either voluntarily or involuntarily disenrolls from the PACE program to apply for other possible services, including medicare or private-pay services; and,

B. The provider will work with the state medicaid agency to ascertain the individual's potential eligibility for other medicaid categories.

[8.315.2.18 NMAC - Rp 8.315.2.18 NMAC, 7/1/2024]

8.315.2.19 PROVISIONS FOR REINSTATEMENT OF PARTICIPANTS TO THE PACE PROGRAM: There are no restrictions placed on a former participant's reinstatement into the PACE program, if the former participant continues to meet financial, non-financial and medical eligibility criteria.

[8.315.2.19 NMAC - Rp 8.315.2.19 NMAC, 7/1/2024]

8.315.2.20 REDETERMINATION: The ISD office will conduct a redetermination at least annually of all financial and non-financial criteria, per the standards of the medicaid eligibility requirements. See Subsection A of 8.280.600.12 NMAC, *Ongoing Benefits, Regular Reviews*. LOC is determined by the HCA's utilization review contractor.

[8.315.2.20 NMAC - Rp 8.315.2.20 NMAC, 7/1/2024]

8.315.2.21 PARTICIPANT RIGHTS: The provider will have written policies and procedures for ensuring the rights of participants as well as educating the participants to the PACE program. These policies and procedures should be presented in a culturally competent format at a language level understandable by the participant or their families (sixth grade level) covering, at a minimum, the following:

A. the enrollment/ disenrollment process;

B. services available through the program;

C. procedures to access services;

D. after hours call-in system;

E. provisions for emergency treatment; and

F. restrictions against using medical providers or services not authorized by the interdisciplinary team.

[8.315.2.21 NMAC - Rp 8.315.2.21 NMAC, 7/1/2024]

8.315.2.22 GRIEVANCE PROCEDURES: The provider will have participant grievance procedures which provide the participants and their family members with a process for expressing dissatisfaction with the program services, whether medical or nonmedical in nature. The procedures will explain and permit an orderly resolution of informal and formal grievances. These procedures should be presented in a culturally competent format at a language level understandable by the participant or their families (sixth grade level). The procedures will:

A. ensure that all provider grievance procedures and any subsequent changes are prior-approved by MAD in writing and included in the enrollment agreement;

B. ensure that a staff member is designated as having primary responsibility for the maintenance of the grievance procedures, review of their operation, and revision of related policies and procedures whenever necessary;

C. ensure that the grievance procedures clearly explain to participants which staff members are assigned to receive formal and informal complaints, the expected procedure, and the time frames for doing so;

D. ensure that a copy of the participant grievance procedures and complaint forms are available to participants;

E. ensure that procedures are in place for tracking, investigating, recording, resolving and appealing decisions concerning grievances made by participants or others; and

F. ensure there is no discrimination against a participant solely on the grounds the participant filed a grievance.

[8.315.2.22 NMAC - Rp 8.315.2.22 NMAC, 7/1/2024]

8.315.2.23 QUALITY ASSURANCE SYSTEM:

A. The provider will have a written plan of quality assurance and improvement which provides for a system of ongoing assessment, implementation, evaluation, and revision of activities related to overall program administration and services. The plan will:

(1) ensure that standards are incorporated into the provider policy and procedure manual; the provider standards will be based on the PACE protocol, applicable PACE standards and applicable licensing and certification criteria;

(2) ensure that goals and objectives provide a framework for quality improvement activities, evaluation and corrective action;

(3) ensure that quality indicators are objective and measurable variables related to the entire range of services provided by the PACE program provider; the methodology should assure that all demographic groups, all care settings, e.g., inpatient, the PACE program center and in-home, will be included in the scope of the quality assurance

review;

(4) ensure that quality indicators are selected for review on the basis of high volume, high risk diagnosis or procedure, adverse outcomes, or some other problem-focused method consistent with the state of the art;

(5) ensure that the evaluation process or procedures review the effectiveness of the interdisciplinary team in its ability to assess participants care needs, identify the participant's treatment goals, assess effectiveness of interventions, evaluate adequacy and appropriateness of service utilization and reorganize treatment plan as necessary;

(6) establish the composition and responsibilities of a quality assurance committee and an ethics committee;

(7) ensure participant involvement in the quality assurance plan and evaluation of satisfaction with services; and

(8) designate an individual to coordinate and oversee implementation of quality assurance activities.

B. The quality assurance committee will hold quarterly meetings with the provider staff, including, but not limited to, the: 1) medical director; 2) interdisciplinary team; and, 3) administrative director. The provider will prepare quarterly written status reports for review at the quality assurance committee meetings. Written status reports will include, at a minimum, a discussion of project progress, problems encountered and recommended solutions, identification of policy or management questions, and requested project plan adjustments.

[8.315.2.23 NMAC - Rp 8.315.2.23 NMAC, 7/1/2024]

8.315.2.24 DATA GATHERING/REPORTING SYSTEM:

A. Standardized data: The provider will ensure the quality of the data according to MAD medium and frequency of reporting.

B. Software: The provider shall make no use of computer software developed pursuant to the contract, except as provided in the contract or as specifically granted in writing by the HCA.

[8.315.2.24 NMAC - Rp 8.315.2.24 NMAC, 7/1/2024]

8.315.2.25 FINANCIAL REPORTING: The provider is required to submit certain financial reports as follows.

A. A budgeted versus actual financial report for the current and year-to-date periods on a monthly basis 45 days after the end of each month. During the first year of operation, the financial report will be submitted on a monthly basis, 45 days after the end of each month. Thereafter, this report will be submitted on a quarterly basis, 45 days after the end of each quarter. The state medicaid agency reserves the right to extend the submission of this report on a monthly basis should provider performance indicate a need for more frequent monitoring.

B. Fiscal data based on cost center accounting structure provided by the state medicaid agency. At the twelfth month, the year-to-date summary will provide the necessary annual data.

C. Submit a cumulative report to the state medicaid agency in the form and detail described by On Lok senior health services/national PACE association. The interim cost report is due 45 days after the end of each providers fiscal quarter and covers the period from the beginning of the fiscal year through the respective quarter.

D. Submit to the state medicaid agency a cost report in the form and detail prescribed by the state medicaid program no later than 180 days after the end of the providers fiscal year.

E. Submit to the state medicaid agency a quarterly balance sheet for those PACE program providers that are separate corporate entities.

[8.315.2.25 NMAC - Rp 8.315.2.25 NMAC, 7/1/2024]

8.315.2.26 UTILIZATION REVIEW: All medicaid services, including services covered under the PACE program, are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

A. Prior authorization: To be eligible for the PACE program, a medicaid recipient must require a nursing facility level of care (LOC). Level of care determinations are made by MAD or its designee. The plan of care (POC) developed by the recipients interdisciplinary team must specify the type, amount and duration of service. Some services specified in the POC may require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior authorization of service does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are financially and medically eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior authorization request denials or other review decisions may request a re-review and a reconsideration. See MAD-953, *Reconsideration of Utilization Review Decisions* [8.350.2 NMAC].

[8.315.2.26 NMAC - Rp 8.315.2.26 NMAC, 7/1/2024]

8.315.2.27 REIMBURSEMENT: PACE program providers must submit claims for reimbursement on the UB 92 claim form or its successor.

See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing.
[8.315.2.27 NMAC - Rp 8.315.2.27 NMAC, 7/1/2024]

HISTORY OF 8.315.2 NMAC:

History of Repealed Material:
8 NMAC 4.MAD.777, Pre-PACE Pilot Project Services, filed 1/20/1998 - Repealed effective 12/1/2006.
8.315.2 NMAC, Program of All-Inclusive Care for the Elderly, filed 11/15/2006 - Repealed effective 7/1/2024.

Other: 8.315.2 NMAC, Program of All-Inclusive Care for the Elderly, filed 11/15/2006 Replaced by 8.315.2 NMAC, Program of All-Inclusive Care for the Elderly effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 324 ADJUNCT SERVICES
PART 10 AMBULATORY SURGICAL CENTER SERVICES

8.324.10.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.324.10.1 NMAC - Rp 8.324.10.1 NMAC, 7/1/2024]

8.324.10.2 SCOPE: The rule applies to the general public.
[8.324.10.2 NMAC - Rp 8.324.10.2 NMAC, 7/1/2024]

8.324.10.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.324.10.3 NMAC - Rp 8.324.10.3 NMAC, 7/1/2024]

8.324.10.4 DURATION: Permanent.
[8.324.10.4 NMAC - Rp 8.324.10.4 NMAC, 7/1/2024]

8.324.10.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.324.10.5 NMAC - Rp 8.324.10.5 NMAC, 7/1/2024]

8.324.10.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.324.10.6 NMAC - Rp 8.324.10.6 NMAC, 7/1/2024]

8.324.10.7 DEFINITIONS: [**RESERVED**]

8.324.10.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.324.10.8 NMAC - Rp 8.324.10.8 NMAC, 7/1/2024]

8.324.10.9 AMBULATORY SURGICAL CENTER SERVICES: New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients, including covered services furnished in ambulatory surgical centers 42 CFR Section 440.20(a). This part describes eligible providers, covered services, service limitations and general reimbursement methodology.
[8.324.10.9 NMAC - Rp 8.324.10.9 NMAC, 7/1/2024]

8.324.10.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation application by the New Mexico medical assistance division (MAD), ambulatory surgical centers certified to participate in medicare under Title XVIII of the Social Security Act as free-standing ambulatory surgical centers are eligible to be reimbursed by medicaid for providing services as ambulatory surgical centers.

(1) The centers for medicare and medicaid (CMS) certify ambulatory surgical centers based on surveys and recommendations submitted by the licensing and certification bureau of the New Mexico department of health (DOH).

(2) Ambulatory surgical centers which are not free-standing but are part of an accredited and certified hospital are subject to 8.311.2 NMAC, *Hospital Services*.

B. Once enrolled, providers receive and are responsible for maintenance of a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. To be eligible for medicaid reimbursement, providers are bound by MAD policies, procedures, billing instructions, reimbursement rates, and all audit, recoupment and withholding provisions unless superceded by federal law, federal regulation or the specific written approval of the MAD director. Providers must be enrolled as medicaid providers before submitting a claim for payment to MAD claims processing contractor.
[8.324.10.10 NMAC - Rp 8.324.10.10 NMAC, 7/1/2024]

8.324.10.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all

federal and state laws and regulations relevant to the provision of medical services, including but not limited to, Title XIX of the Social Security Act, the Medicare and Medicaid Anti-Fraud Act, and the state Medicaid Fraud Act. Providers also agree to conform to MAD policies and instructions as specified in this manual and its appendices, as updated. See 8.302.1 NMAC, *General Provider Policies*.

A. Recipient eligibility determination: Providers must verify that services they furnish are provided to eligible recipients.

(1) Providers may verify eligibility through several mechanisms, including the use of an automated voice response system, contacting the medicaid fiscal agent contractor eligibility help desk, contracting with a medicaid eligibility verification system (MEVS) vendor, or contracting with a medicaid magnetic swipe card vendor.

(2) Providers must verify that recipients are eligible for medicaid throughout periods of continued or extended services. By verifying client eligibility, a provider is informed of restrictions that may apply to a recipient's eligibility.

B. Requirements for updating information: Providers must furnish in writing to MAD or MAD claims processing contractor with complete information on changes in their address, license, certification, board specialties, corporate name or corporate ownership, and a statement as to the continuing liability for the provider for any dissolution of other disposition of the health care provider or person. MAD or the MAD claims processing contractor must receive this information at least 60 days before the change. Any payment made by MAD based upon erroneous or outdated information is subject to recoupment.

C. Documentation requirements: Providers must maintain records to fully disclose the nature, quality, amount, and medical necessity of the services furnished to recipients who are currently receiving or who have received medical services in the past 42 CFR 431.107(b). Documentation supporting medical necessity must be legible and available to medicaid upon request. See 8.302.1 NMAC, *General Provider Policies.*

[8.324.10.11 NMAC - Rp 8.324.10.11 NMAC, 7/1/2024]

8.324.10.12 COVERED SERVICES:

A. Medicaid covers ambulatory surgical center facility services, as required by the condition of the recipient and if the following conditions are met:

(1) the surgical procedure and use of the facility are medically necessary and are covered by medicaid; and

(2) all medicaid requirements for the surgery, such as applicable consent forms or prior authorization requirements, are met by the physician.

B. See 8.310.2 NMAC, *Medical Services Providers*.

[8.324.10.12 NMAC - Rp 8.324.10.12 NMAC, 7/1/2024]

8.324.10.13 NONCOVERED SERVICES: Ambulatory surgical center services are subject to the limitations and coverage restrictions which exist for other medicaid services. If the surgery is non-covered, the anesthesia is non-covered. See 8.301.3 NMAC, *General Noncovered Services*.

A. Direct payment to physician. Ambulatory surgical centers are not reimbursed by medicaid for physician fees. Reimbursement for physician fees is made directly to the provider of the service.

B. Services furnished to dual eligible recipients. By federal regulation, the medicare program pays ambulatory surgical centers only for an approved list of specific surgical procedures. Medicare is the primary payment source for individuals who are eligible for both medicare and medicaid. For these recipients, medicaid will not pay an ambulatory surgical center for a surgical procedure denied by medicare. Ambulatory surgical centers must refer these recipients to facilities which medicare pays for the surgical procedure, such as an outpatient hospital.

[8.324.10.13 NMAC - Rp 8.324.10.13 NMAC, 7/1/2024]

8.324.10.14 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

A. Prior authorization: Certain procedures or services can require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior authorization of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior authorization request denials or other review decisions can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions*.

[8.324.10.14 NMAC - Rp 8.324.10.14 NMAC, 7/1/2024]

8.324.10.15 REIMBURSEMENT: Ambulatory surgical centers must submit claims for reimbursement on the CMS-1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on

documentation, billing and claims processing.

A. Inclusion of all services in the facility fee: All services furnished by the facility are considered reimbursed in the facility fee and cannot be billed separately. The amount paid will be the lesser of the facility's usual and customary charge or the maximum allowed by medicaid.

B. Reimbursement methodology: The facility fee maximum is established at a level which considers the surgical procedure and the area in which the facility is located. Each surgical procedure is assigned to one of nine surgical groups, based on the complexity of the procedure. Each of these surgical groups has a separate reimbursement level. The level of reimbursement is determined by medicaid by utilizing the medicare carrier for procedures payable to ambulatory surgical centers by medicare regulations. The list of surgeries payable under medicare regulations also designates the assigned surgical group for payment purposes. The list is available from the medicare carrier.

(1) For those procedures for which medicare has not established a reimbursement level, MAD assigns the procedure to one of the nine surgical groups. The assignment is based upon the complexity of the procedure or its similarity to procedures within the surgical groups developed by medicare.

(2) Reimbursement is made at the level established by medicaid for that surgical group.

C. Reimbursement for multiple procedures: When more than one covered surgical procedure is performed during the same surgical encounter, reimbursement is made at the rate for the most complex procedure plus fifty percent of the applicable rate for any additional procedures.

D. Reimbursement for laboratory services:

(1) The following laboratory services are considered included in the facility fee and are not reimbursed separately:

(a) hematocrit;

(b) hemoglobin (colorimetric); and

(c) routine urinalysis, without microscopy.

(2) For an ambulatory surgical center to be reimbursed for laboratory tests which are not included in the facility fee, the following conditions must be met:

(a) ambulatory surgical center laboratories must be separately certified and enrolled as clinical laboratories with valid CLIA numbers;

(b) laboratory tests billed must fall within the approved laboratory specialties/ subspecialties for which the laboratory has been certified;

(c) laboratories must have separate New Mexico medical assistance program provider participation applications approved by MAD to bill for laboratory tests not included in the facility fee; and

(d) laboratory tests must be performed on the premises of ambulatory surgical centers and not sent out to reference laboratories. See 8.324.2 NMAC, *Laboratory Services*.

E. Reimbursement for diagnostic imaging and therapeutic radiology services: Diagnostic radiological, diagnostic ultrasound, peripheral vascular flow measurements and nuclear medicine studies furnished by a facility are considered covered services, but payment is considered to be made within the facility fee and are not separately reimbursed services. See 8.324.3 NMAC, *Diagnostic Imaging and Therapeutic Radiology Services*.
[8.324.10.15 NMAC - Rp 8.324.10.15 NMAC, 7/1/2024]

HISTORY OF 8.324.10 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD-Rule 310.2200, Ambulatory Surgical Center Services, filed 12/17/1985.
MAD Rule 310.22, Ambulatory Surgical Center Services, filed 4/17/1992.

History of Repealed Material:
MAD Rule 310.22, Ambulatory Surgical Center Services, filed 4/17/1992 - Repealed effective 2/1/1995.
8.324.10 NMAC, Ambulatory Surgical Center Services, filed 10/12/2004 - Repealed effective - 7/1/2024.

Other: 8.324.10 NMAC, Ambulatory Surgical Center Services, filed 10/12/2004 Replaced by 8.324.10 NMAC, Ambulatory Surgical Center Services effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 325 SPECIALTY SERVICES
PART 2 DIALYSIS SERVICES

8.325.2.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.325.2.1 NMAC - Rp 8.325.2.1 NMAC, 7/1/2024]

8.325.2.2 SCOPE: The rule applies to the general public.
[8.325.2.2 NMAC - Rp 8.325.2.2 NMAC, 7/1/2024]

8.325.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et.

seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.325.2.3 NMAC - Rp 8.325.2.3 NMAC, 7/1/2024]

8.325.2.4 DURATION: Permanent.
[8.325.2.4 NMAC - Rp 8.325.2.4 NMAC, 7/1/2024]

8.325.2.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.325.2.5 NMAC - Rp 8.325.2.5 NMAC, 7/1/2024]

8.325.2.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.325.2.6 NMAC - Rp 8.325.2.6 NMAC, 7/1/2024]

8.325.2.7 DEFINITIONS: [**RESERVED**]

8.325.2.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.325.2.8 NMAC - Rp 8.325.2.8 NMAC, 7/1/2024]

8.325.2.9 DIALYSIS SERVICES: Dialysis services are covered as an optional medical service for New Mexico medicaid program (medicaid) recipients 42 CFR Sections 440.10, 440.20; 440.50. This part describes eligible dialysis providers, covered services, service limitations, and general reimbursement methodology.
[8.325.2.9 NMAC - Rp 8.325.2.9 NMAC, 7/1/2024]

8.325.2.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation applications licensed practitioners or facilities that meet applicable requirements by the New Mexico medical assistance division (MAD), the following providers are eligible to be reimbursed for furnishing dialysis services to medicaid recipients:

(1) individuals licensed to practice medicine or osteopathy;

(2) facilities certified by the licensing and certification bureau of the department of health to furnish renal dialysis services; and

(3) hospitals eligible to participate in the New Mexico medicaid program. See 8.311.2 NMAC, Hospital Services.

B. Once enrolled, providers receive and are responsible for maintenance of a packet of information, which includes medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they understand these materials. To be eligible for medicaid reimbursement, providers are bound by MAD policies, procedures, billing instructions, reimbursement rates, and all audit, recoupment and withholding provisions unless superseded by federal law, or federal regulation. Providers must be enrolled as medicaid providers before submitting a claim for payment to the MAD claims processing contractor.
[8.325.2.10 NMAC - Rp 8.325.2.10 NMAC, 7/1/2024]

8.325.2.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients agree to comply with all federal and state laws and regulations relevant to the provision of medical services, including but not limited to, Title XIX of the Social Security Act, the Medicare and Medicaid Anti-Fraud Act, and the state Medicaid Fraud Act. Providers also agree to conform to the MAD policies and instructions as specified in this manual and its appendices, as updated.

A. Recipient eligibility verification: Providers must verify that services they furnish are provided to eligible recipients. Providers must verify that recipients are eligible and remain eligible for medicaid through periods of continued and extended services. By verifying eligibility, a provider is informed of restrictions that may apply to recipient's eligibility. Providers may verify eligibility through several mechanisms, including using an automated voice response system, contacting the medicaid fiscal agent contractor eligibility help desk, contracting with a medicaid eligibility verification system (MEVS) vendor, or contracting with a medicaid magnetic swipe card vendor.

B. Requirements for updating information: Providers must furnish in writing to MAD or the MAD claims processing contractor with complete information changes in their address, license, certification, board specialties, corporate name or corporate ownership, and a statement as to the continuing liability of the provider for any recoverable obligation to MAD which occurred or may have occurred prior to any sale, merger, consolidation, dissolution or other disposition of the health care provider group or individual.

C. Documentation requirements: Providers must maintain records to fully disclose the nature, quality, amount, and medical necessity of services furnished to recipients who are currently receiving or who have received medical services in the past [42 CFR 43.107(b)].
[8.325.2.11 NMAC - Rp 8.325.2.11 NMAC, 7/1/2024]

8.325.2.12 COVERED SERVICES: Medicaid covers renal dialysis services for the first three months of dialysis pending the establishment of medicare eligibility. Medicare becomes the

primary reimbursement source for individuals who meet the medicare eligibility criteria. Dialysis providers must assist medicaid recipients in applying for and pursuing final medicare eligibility determinations. Medicaid covers medically necessary dialysis supplies furnished to home-dialyzed recipients. Medicaid covers medically necessary renal dialysis services furnished by providers as required by the condition of the recipient. Medicaid covers the following specific renal dialysis services:

A. Supplies, equipment and services included in the renal dialysis services composite rate: The facility reimbursement fee includes all renal-related facility and home dialysis services, including supplies and equipment. The following are some of the drugs, items and supplies included in the facility fee:

(1) hypertonic saline;

(2) dextrose (glucose);

(3) mannitol or similar product used for volume control;

(4) heparin;

(5) protamine;

(6) antiarrhythmics;

(7) antihistamines;

(8) antihypertensives;

(9) pressor drugs;

(10) antibiotics (when used at home by a patient to treat an infection of the catheter site or peritonitis associated with peritoneal dialysis);

(11) oxygen;

(12) filters;

(13) bicarbonate dialysate;

(14) cardiac monitoring;

(15) catheters and catheter changes;

(16) suture removal kits and suture removal;

(17) dressing supplies;

(18) crash cart usage for cardiac arrest;

(19) declotting of shunt performed by facility staff in the dialysis unit;

(20) staff time to administer blood;

(21) staff time to administer separately billable parenteral items; and

(22) staff time used to collect all specimens for laboratory tests.

B. Routine laboratory tests: Routine laboratory tests are included in the facility fee. The following list specifies the covered routine tests and allowed frequencies. Routine tests at greater frequencies are reimbursable in addition to the facility fee but require medical justification by a physician.

(1) For hemodialysis, peritoneal dialysis and continuous cyclic peritoneal dialysis (CCPD):

(a) per dialysis:

(i) hematocrit;

(ii) clotting time;

(iii) hemoglobin.

(b) weekly:

(i) prothrombin time for patients on anticoagulant therapy;

(ii) creatinine; and

(iii) BUN;

(c) monthly:

(i) CBC;

(ii) calcium;

(iii) potassium;

(iv) chloride;

(v) alkaline phosphatase;

(vi) SGOT;

(vii) bicarbonate;

(viii) phosphate;

(ix) total protein;

(x) albumin; or

(xi) LDH.

(2) For continuous abdominal peritoneal dialysis when the facility bills a facility charge (CAPD): Monthly: BUN; magnesium; HCT; calcium; HGB; albumin; creatinine; phosphate; LDH; sodium; potassium; SGOT; CO_2; total protein; dialysate protein; alkaline phosphatase.

[8.325.2.12 NMAC - Rp 8.325.2.12 NMAC, 7/1/2024]

8.325.2.13 SERVICE LIMITATIONS: Tests that are listed as separately billable (not included in the composite rate) and are performed at a frequency greater than specified in the composite rate require medical justification and are covered when furnished at specified frequencies.

A. Tests for hemodialysis, peritoneal dialysis and CCPD: (Not included in the composite rate). These services may be billed separately at the specified frequencies.

(1) Monthly:

(a) alkaline phosphatase;

(b) alkaline phosphatase;

(c) blood urea nitrogen (BUN);

(d) serum bicarbonate (CO_2);

(e) dialysis protein;

(f) hematocrit;

(g) hemoglobin;

(h) lactic dehydrogenase (LDH);

(i) magnesium;

(j) serum albumin;

(k) serum creatinine;

(l) serum phosporus;

(m) serum potassium;

(n) SGOT;

(o) sodium;

(p) total protein;

(q) serum calcium;

(r) hepatitis test.

(2) Once every three months:

(a) serum aluminum;

(b) serum ferritin;

(c) nerve conductor velocity test;

(d) EKG.

(3) Once every six months: chest x-ray

(4) Once every year: bone survey

B. Tests for CAPD: (Not included in the composite rate). These services may be billed separately at the specified frequencies.

(1) Once every three months:

(a) white blood count (WBC);

(b) platelet count;

(c) red blood count.

(2) Once every six months:

(a) 24-hour urine volume;

(b) residual renal function;

(c) chest x-ray;

(d) EKG;

(e) MNCV.

C. Training: Medicaid reimburses for hemodialysis, peritoneal dialysis, continuous cycling peritoneal dialysis and continuous abdominal peritoneal dialysis training sessions if furnished by a renal dialysis facility certified to provide these services. Dialysis training must be performed in the dialysis facility. 15 training sessions are allowed without medical justification. To be reimbursed for additional training sessions, a medical justification must be attached to the claim.
[8.325.2.13 NMAC - Rp 8.325.2.13 NMAC, 7/1/2024]

8.325.2.14 NONCOVERED SERVICES: Dialysis services are subject to the limitations and coverage restrictions of other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*.
[8.325.2.14 NMAC - Rp 8.325.2.14 NMAC, 7/1/2024]

8.325.2.15 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

A. Prior authorization: Certain procedures or services can require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior authorization of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior authorization request denials or other review decisions can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions*.
[8.325.2.15 NMAC - Rp 8.325.2.15 NMAC, 7/1/2024]

8.325.2.16 REIMBURSEMENT: Dialysis facilities must submit claims for reimbursement on the UB-92 claim form or its successor. Physicians must submit for reimbursement on the CMS-1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. The facility's composite rate reimbursement is a comprehensive payment for all in facility and home dialysis services. Providers cannot bill separately for services inclusive of the composite rate, as defined by medicare, even though payment is made at the medicaid fee schedule. Physicians services are not included in the facilities composite rate. Physicians may bill for their professional services according to the policies and procedures outlined in the 8.310.2 NMAC, *Medical Services Providers*. Laboratory procedures and radiology procedures that are not part of the facilities composite rate, as defined by medicare, may be billed separately.

A. Certified hospital-based dialysis facilities are reimbursed at a rate determined by the medicaid outpatient hospital reimbursement methodology.

B. Hospital providers are reimbursed for inpatient renal dialysis at a rate determined by the medicaid inpatient hospital reimbursement methodology.

C. Renal dialysis facilities acting as suppliers to a home-dialyzed recipient can bill medicaid for the necessary supplies furnished to the recipient only if the facility is not billing a facility fee. Facilities cannot bill for both a facility fee and supplies.
[8.325.2.16 NMAC - Rp 8.325.2.16 NMAC, 7/1/2024]

HISTORY OF 8.325.2 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

ISD-Rule 310.2100, Dialysis Services, filed 4/8/1985.

History of Repealed Material: ISD-Rule 310.2100, Dialysis Services, filed 4/8/1985 - Repealed effective 2/1/1995.
8.325.2 NMAC, Dialysis Services, filed 10/15/2004 - Repealed effective 7/1/2024.

Other: 8.325.2 NMAC, Dialysis Services, filed 10/15/2004 Replaced by 8.325.2 NMAC, Dialysis Services, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 325 SPECIALTY SERVICES
PART 4 HOSPICE CARE SERVICES

8.325.4.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.325.4.1 NMAC - Rp 8.325.4.1 NMAC, 7/1/2024]

8.325.4.2 SCOPE: The rule applies to the general public.
[8.325.4.2 NMAC - Rp 8.325.4.2 NMAC, 7/1/2024]

8.325.4.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.325.4.3 NMAC - Rp 8.325.4.3 NMAC, 7/1/2024]

8.325.4.4 DURATION: Permanent.
[8.325.4.4 NMAC - Rp 8.325.4. NMAC, 7/1/2024]

8.325.4.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.325.4.5 NMAC - Rp 8.325.4.5 NMAC, 7/1/2024]

8.325.4.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.325.4.6 NMAC - Rp 8.325.4.6 NMAC, 7/1/2024]

8.325.4.7 DEFINITIONS: [**RESERVED**]

8.325.4.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.325.4.8 NMAC - Rp 8.325.4.8 NMAC, 7/1/2024]

8.325.4.9 HOSPICE CARE SERVICES: Hospice services are covered as an optional medical service for New Mexico medicaid program (medicaid) recipients. Hospice services provide palliative and supportive services to meet the physical, psychological, social, and spiritual needs of terminally ill medicaid recipients and their families. This part describes eligible providers covered services, service limitations, and general reimbursement methodology.
[8.325.4.9 NMAC - Rp 8.325.4.9 NMAC, 7/1/2024]

8.325.4.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation by the New Mexico medical assistance division (MAD), hospice agencies meeting the following conditions are eligible to be reimbursed for providing hospice care services:

(1) meet the conditions for participation: see 42 CFR 418.50 et. seq.;

(2) licensed and certified by the licensing and certification bureau of the New Mexico department of health (DOH); and

(3) are a public or private non-profit or for profit agency or a subdivision of either, primarily engaged in providing care to terminally ill individuals.

B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.
[8.325.4.10 NMAC - Rp 8.325.4.10 NMAC, 7/1/2024]

8.325.4.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all federal and state laws and regulations relevant to the provision of medical services, including but not limited to Title XIX of the Social Security Act, the Medicare and Medicaid Anti-Fraud Act, and the state Medicaid Fraud Act. Providers also agree to conform to MAD policies and instructions as specified in this manual and it appendices, as updated. See, 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records to fully disclose the nature, quality, amount, and medical necessity of the services furnished to recipients who are currently receiving or who have

received medical services in the past 42 CFR 431.107(B). Documentation supporting medical necessity must be legible and available to medicaid upon request. See 8.302.1 NMAC, *General Provider Policies*.
[8.325.4.11 NMAC - Rp 8.325.4.11 NMAC, 7/1/2024]

8.325.4.12 ELIGIBLE RECIPIENTS: To be eligible for hospice care, a physician must provide a written certification that the recipient has a terminal illness. Recipients must elect to receive hospice care for the duration of the election period.

A. Certification of terminal illness: The hospice must obtain a written certification statement signed by the hospice medical director, physician member of the hospice interdisciplinary team or recipient's attending physician that the recipient is terminally ill. The physician must sign the written certification within seven calendar days of the date services are initiated. Certification statements must include information that is based on the recipient's medical prognosis, and the life expectancy is six months or less if the terminal illness runs its typical course.

(1) If a recipient receives hospice benefits beyond 210 days, the hospice must obtain a written recertification statement from the hospice medical director or the physician member of the hospice interdisciplinary group before the 210-day period expires.

(2) Hospice benefits furnished beyond the 210-day period may be subject to medical review.

B. Election of hospice care: Recipients who are eligible for hospice care must elect to receive hospice services. Recipients or their legal representatives elect hospice services by filing an election statement with a particular hospice designee.

(1) For the duration of the election, recipients who elect hospice care, waive their right to medicaid payment for the following services:

(a) services related to treatment of the terminal condition or related condition for which hospice care was elected; and

(b) services equivalent to hospice care, such as home health services, and private duty nursing services under enhanced early and periodic screening, diagnosis and treatment (EPSDT).

(2) Recipients who are receiving home and community based waiver services or other in-home services based on a plan of care must have the plan of care coordinated with the hospice provider and adjusted as necessary to avoid duplicative or unnecessary services.

(3) Hospice coverage continues for 210-day time periods, as long as recipients remain in hospice care and do not cancel the election.

(4) Recipients or their representatives can designate an effective date for the election. The effective date begins with the first or any subsequent day of hospice services.

C. Election statement: The election statement must include the following elements:

(1) designation of the hospice that will provide care;

(2) designation of the recipient's attending physician;

(3) acknowledgement that the recipients or representatives has been given a full understanding of the palliative rather than curative nature of hospice care;

(4) effective date of the election; and

(5) the recipient's or the representative's signature.

D. Revocation of hospice care services:

(1) A recipient or representative can cancel the election of hospice care at any time by filing a statement with MAD or its designee. The statement must include the following information:

(a) recipient is revoking their election for medicaid coverage of hospice care;

(b) effective date of the revocation, which is not earlier than the actual date of the revocation; and

(c) the recipient's or the representative's signature.

(2) Upon revocation of the election of hospice services, recipients are no longer covered for medicaid hospice services.

(3) Recipients can elect to receive hospice care services again at any time. The same process for approval of services must be followed when the second election occurs. A new plan of care, certification statement, and election statement must be submitted to MAD or its designee.

E. Change of designated hospice:

(1) Recipients or their representatives can change designated hospice providers by filing statements with MAD or its designee. A statement must contain the following information:

(a) name of the hospice the recipient is leaving;

(b) name of the hospice the recipient is entering; and

(c) effective date of the change.

(2) A change in ownership or name of a hospice is not considered a change in the recipient's designated hospice.
[8.325.4.12 NMAC - Rp 8.325.4.12 NMAC, 7/1/2024]

8.325.4.13 COVERED SERVICES AND SERVICE LIMITATIONS: For recipients electing hospice care, medicaid covers hospice core services furnished to eligible recipients that are reasonable and necessary for the palliation or symptom management of a recipient's terminal illness and related conditions. Hospice core

services include the medications, durable medical equipment and medical supplies needed to deliver palliative care. Hospice providers are reimbursed for the delivery of core services based on daily rate.

A. The hospice services necessary for a specific recipient must be documented in an individualized treatment plan. The plan must be developed by attending physicians, medical directors and interdisciplinary groups and must meet certain requirements: See 42 CFR 418.50 et. seq.

(1) Hospices must designate a registered nurse to coordinate the implementation of each recipient's plan of care.

(2) The interdisciplinary group, including nursing services, medical social services, physician services and counseling services practitioners are responsible for the following:

(a) developing the plan of care;

(b) providing or supervising hospice care and services;

(c) reviewing and updating the plan of care;

(d) establishing policies for daily provision of hospice care and services; and

(e) coordinating with other medicaid support service providers such that the plan of care is not duplicative of hospice services.

(3) All hospice services must be available 24 hours per day to the extent necessary to meet the needs of the terminally ill recipients.

B. Core services: Medicaid covers the following nursing, medical social service, physician and counseling services as core hospice services:

(1) nursing services furnished by or under the supervision of registered nurses and based on the treatment plan and recognized standards of practice;

(2) medical social services furnished by a qualified social worker under the direction of a physician;

(3) physician services performed by a doctor of medicine or osteopathy, including palliation and management of terminal illness and related conditions and the recipient's general medical needs not met by the recipient's attending physician;

(4) counseling services available to recipients and family members; counseling can be furnished for training families to provide care and preparing recipients and families to adjust to the recipient's approaching death; counseling includes dietary, spiritual and other counseling for recipients and families and bereavement counseling furnished after a recipient's death; the following counseling services must be furnished by hospices:

(a) organized program of bereavement services under the supervision of qualified professionals; the plan of care for these services must reflect family needs and provide a clear outline of the type, frequency and duration of counseling; bereavement counseling is a required but non-reimbursed service;

(b) dietary counseling, when applicable, furnished by qualified professionals;

(c) spiritual counseling, including notice to recipients of the availability of clergy; and

(d) other counseling, furnished by members of the interdisciplinary group or other qualified professionals.

(5) home health aide and homemaker services at frequencies sufficient to meet the needs of recipients; home health aides must meet training and qualification requirements; see 42 CFR 484.36; registered nurses must visit a recipient's residence every two weeks to assess the performance of the aide or homemaker services;

(6) physical therapy, occupational therapy and speech-language therapy must be available if needed to control symptoms or maintain activities of daily living;

(7) durable medical equipment, medical supplies, and pharmacy services related to the palliation and management of the terminal illness and related conditions:

(a) See 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies*.

(b) Medicaid covers only drugs and biologicals defined in Section 1861 (t) of the Social Security Act and used primarily for pain relief and symptom control related to terminal illness. All drugs and biologicals must be administered in accordance with accepted standards of practice.

(c) Every hospice must have a policy for the disposal of controlled drugs kept in the recipient's home when those drugs are no longer needed.

(d) Drugs and biologicals are to be administered only by the following individuals:

(i) a licensed nurse or physician;

(ii) the recipient with the approval of the attending physician; and

(iii) any other individual in accordance with applicable state and local laws; the individual and each drug and biological they are authorized to administer must be specified in the recipient's plan of care.

(8) short-term inpatient services for pain control and symptom management delivered in a facility which is a medicaid provider; and

(9) short-term inpatient respite services furnished in a facility which is a medicaid provider; medicaid covers five consecutive days of inpatient respite care which can be needed on an infrequent basis to provide respite for the recipient's family or primary caregivers.

(a) The need for and duration of inpatient

respite services must be specified in the treatment plan.

(b) Inpatient respite must be furnished by a hospice facility, hospital, or nursing facility that meets the requirements in 42 CFR Section 418.100.

C. Continuous nursing care services: Medicaid covers continuous nursing care required to achieve pain control and symptom management. Continuous care can be covered during a period of crisis if the recipient needs such care to achieve palliation and manage acute medical symptoms at home.

(1) To be considered continuous care, nursing care must be furnished for eight consecutive hours in a 24 hour period. Medicaid covers the homemaker or aide services furnished during the other 16 hours as routine home care.

(2) Medicaid covers continuous nursing services for a maximum of 72 consecutive hours.

[8.325.4.13 NMAC - Rp 8.325.4.13 NMAC, 7/1/2024]

8.325.4.14 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: Hospice services are subject to utilization review for medical necessity and program compliance. These reviews can be performed before services are furnished, after services are furnished and before payment is made, after payment is made, or at any point in the service or payment process. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive utilization review instructions and documentation forms which assists in the receipt of prior authorization and claims processing.

A. Prior authorization: Hospice services do not require prior authorization. Services remain subject to review at any point in the payment process for medical necessity.

B. Eligibility determination: Prior authorization of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who are dissatisfied with a utilization review decision or action can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions*.

[8.325.4.14 NMAC - Rp 8.325.4.14 NMAC, 7/1/2024]

8.325.4.15 NONCOVERED SERVICES: Hospice services are subject to the limitations and coverage restrictions that exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*. Medicaid does not cover the following hospice services.

A. Core services furnished by nonemployees. Core services when furnished routinely by non-employees or contracted staff are not covered by medicaid. A hospice can bill only for contracted staff necessary to supplement hospice employees in meeting recipient needs during periods of peak patient loads.

B. Bereavement counseling furnished to families after a recipient's death is a required hospice service, however, hospice agencies are not paid an additional amount for furnishing these services.

C. Inpatient respite care for more than five consecutive days. After five days, additional inpatient respite care is reimbursed as routine home care. Respite care cannot be furnished if the recipient lives in a long-term care facility.

D. Hospice services furnished by nondesignated hospices are not a covered benefit.

[8.325.4.15 NMAC - Rp 8.325.4.15 NMAC, 7/1/2024]

8.325.4.16 PATIENT SELF DETERMINATION ACT: All adult recipients must be informed of their right to make health decisions, including the right to accept or refuse medical treatment, as specified in the Patient Self-Determination Act. See 8.302.1 NMAC, *General Provider Policies*.

[8.325.4.16 NMAC - Rp 8.325.4.16 NMAC, 7/1/2024]

8.325.4.17 REIMBURSEMENT: Hospice providers must submit claims for reimbursement on the UB-92 claim form or its successor. Election documentation must be submitted with the initial claim. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing. Medicaid reimbursement for hospice care is made at one of four prospective daily rates, depending on the level of care furnished. The only retroactive adjustment to reimbursement is the year-end application of the limitation on inpatient care payment. Physician services are reimbursed separately from the hospice daily rate.

A. Payment for hospice care:

(1) Payment rates for hospice care services are determined by the centers for medicare and medicaid services (CMS), with local adjustments for wage differences within each category. Reimbursement for hospice services is based on one of four all-inclusive daily rate categories. The daily rate for each category includes all services necessary for palliative care, such as the purchase of needed medications, durable medical equipment, and medical supplies. The following are basic categories of hospice care:

(a) "routine home care day" defined as a day on which the recipient receives hospice care at home that is not defined as continuous care;

(b) "continuous home care day" defined as a day on which the recipient is not in an inpatient facility and receives nursing services for eight consecutive hours in a 24 hour period; this care is furnished only during brief periods of crisis to maintain the recipient at home; home health aide or homemaker services can also be

furnished on a continuous basis, but these services are considered routine care;

(c) "inpatient respite care day" defined as a day on which a recipient receives care in approved facilities on a short-term basis to provider respite for the recipient's family or primary caregiver; and

(d) "general inpatient care day" defined as a day on which a recipient receives care in inpatient facilities for pain control or acute or chronic symptom management that cannot be managed in other settings.

(2) Reimbursement is made to a hospice for each day on which recipients are eligible for hospice care. Reimbursement is based on the appropriate payment amount for each day, regardless of the category of services furnished on any given day.

(3) Reimbursement for a continuous home care day varies, depending on the number of hours of continuous nursing services furnished. The continuous home care rate is divided by 24 to yield an hourly rate. The number of hours of care furnished during the continuous home care day is multiplied by the hourly rate to yield the continuous home care payment for that day. Medicaid reimbursement for continuous home care is limited to a maximum of 72 consecutive hours of service.

(4) The inpatient reimbursement rate for approved facility for short-term inpatient care depends on the category of care furnished, either inpatient respite or general inpatient.

(a) Reimbursement for inpatient respite care is limited to a maximum of five consecutive days at a time. Medicaid pays for the sixth and any subsequent day of respite care at the routine home care rate.

(b) Medicaid pays the inpatient rate for the admission date and all subsequent inpatient days. For the discharge day, the applicable home care rate is reimbursed. Reimbursement for the discharge day when the recipient is discharged deceased is made at the inpatient rate.

(c) Reimbursement for all inpatient care is subject to a limitation that total inpatient care days for medicaid recipients cannot exceed twenty percent of the total days for which these recipients elected hospice care. The calculation and any necessary retroactive adjustment of overall payments per provider is completed during the cap period. See 42 CFR 418.302 (f).

B. Reimbursement for physician services:

(1) Medicaid covers the following services performed by hospice physicians as part of the general reimbursement rate for hospice care services:

(a) general supervisory services of the medical director; and

(b) participation in establishing, reviewing and updating plans of care, supervision of care and services, and establishment of governing policies by the physician member of the interdisciplinary group.

(2) For direct patient care services furnished by a hospice employee or a physician working under arrangement with the hospice, not listed above, medicaid reimburses the hospice for each procedure at the lesser of the medicaid fee schedule or the amount billed.

(3) Medicaid does not pay for physician services furnished on a volunteer basis.

(4) Medicaid does not cover physician services furnished by the recipient's attending physician as a hospice service, if he or she is not an employee of the hospice or providing services under arrangements with the hospice. Only the attending physician can bill for these services.

[8.325.4.17 NMAC - Rp 8.325.4.17 NMAC, 7/1/2024]

8.325.4.18 HOSPICE SERVICES FOR RECIPIENTS IN NURSING FACILITIES: If a recipient does not have family or friends to provide the necessary care to allow the recipient to remain at home (home does not include an adult foster care setting or a home for the aged), a recipient living in a nursing facility (NF) can elect to receive hospice care. The NF is considered the recipient's place of residence. The NF and the designated hospice must sign a cooperative agreement that the hospice is responsible for the professional management of the recipient's hospice care and the NF provides room and board.

A. Room and board services: The agreement must specify that the NF provides the following room and board services:

(1) perform personal care services;

(2) help with activities of daily living;

(3) provide socializing activities;

(4) administer medication;

(5) maintain room cleanliness; and

(6) supervise the use of durable medical equipment and prescribed therapies.

B. Reimbursement for nursing facility room and board: For medicaid recipients living in a NF who elect hospice care, medicaid pays the hospice an additional per diem amount for routine home care and continuous home care days for the NF room and board services.

(1) The room and board reimbursement is ninety-five percent of the medicaid rate paid to the specific NF for that recipient.

(2) For dual-eligible medicare/medicaid recipients who live in an NF and elect the medicare hospice benefit, medicaid pays the hospice for the NF room and board services if the hospice and NF have a written agreement delineating responsibilities for hospice care and room and board services.

(a) For dual-eligible recipients, medicaid pays any coinsurance amounts for drugs, biological and respite care.

See 42 CFR Section 418.400.

(b) For dual-eligible recipients, direct medicaid payment for service to the NF is discontinued.

[8.325.4.18 NMAC - Rp 8.325.4.18 NMAC, 7/1/2024]

HISTORY OF 325.4 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
MAD Rule 310.26, Hospice Services, filed 3/20/1989.

History of Repealed Material:
MAD Rule 310.26, Hospice Services, filed 3/20/1989 - Repealed effective 2/1/1995.
8.325.4.1 NMAC, Hospice Care Services, filed 2/13/2006 - Repealed effective 7/01/2024.

Other: 8.325.4.1 NMAC, Hospice Care Services, filed 2/13/2006 Replaced by 8.325.4.1 NMAC, Hospice Care Services, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 325 SPECIALTY SERVICES
PART 9 HOME HEALTH SERVICES

8.325.9.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.325.9.1 NMAC - 8.325.9.1 NMAC, 7/1/2024]

8.325.9.2 SCOPE: The rule applies to the general public.
[8.325.9.2 NMAC - 8.325.9.2 NMAC, 7/1/2024]

8.325.9.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Sections 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.325.9.3 NMAC - 8.325.9.3 NMAC, 7/1/2024]

8.325.9.4 DURATION: Permanent.
[8.325.9.4 NMAC - 8.325.9.4 NMAC, 7/1/2024]

8.325.9.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.325.9.5 NMAC - 8.325.9.5 NMAC, 7/1/2024]

8.325.9.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.325.9.6 NMAC - 8.325.9.6 NMAC, 7/1/2024]

8.325.9.7 DEFINITIONS: [**RESERVED**]

8.325.9.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.325.9.8 NMAC - 8.325.9.8 NMAC, 7/1/2024]

8.325.9.9 HOME HEALTH SERVICES: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients, including home health services 42 CFR, Section 484 and 42 CFR, Section 440.70. This part describes eligible providers, covered services, service limitations, and the general reimbursement methodology.
[8.325.9.9 NMAC - 8.325.9.9 NMAC, 7/1/2024]

8.325.9.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), home health agencies that meet the following conditions are eligible to be reimbursed for furnishing services:

(1) meet the conditions of participation. See 42 CFR, Section 484 Subpart B;

(2) are licensed and certified by the licensing and certification bureau of the HCA to meet all standards for participation in a federal program established under Title XVIII (medicare) of the Social Security Act. Any provider participating only in medicaid must be licensed and certified to comply with the standards for medicare participation; and

(3) are public agencies, private for-profit agencies, or private non-profit agencies primarily engaged in furnishing skilled nursing services and at least one other therapeutic service.

B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.
[8.325.9.10 NMAC - 8.325.9.10 NMAC, 7/1/2024]

8.325.9.11 PROVIDER RESPONSIBILITIES:

A. Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General*

Provider Policies.

B. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Providers shall have written policies concerning the acceptance of recipients and the feasibility of meeting the recipient's needs in the home care setting, which include, but are not limited to:

(1) an evaluation visit in the recipient's residence to consider the physical facilities available, capabilities and attitudes of the recipient, family members or significant others, the availability of care givers, if any, to help in the care of the patient, and the appropriateness of home health care for meeting the recipient's needs in a safe environment;

(2) the recipient's need to receive medical care at home;

(3) orders from the recipient's physician;

(4) documentation in the medical record of (1), (2) and (3). Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC, *General Provider Policies*.

[8.325.9.11 NMAC - 8.325.9.11 NMAC, 7/1/2024]

8.325.9.12 ELIGIBLE RECIPIENTS:

A. Recipients must have a medical need to receive care at home to be eligible for home health agency services and must be certified as such by their attending physicians. A medical need to receive care at home means that the recipient has a condition caused by illness or injury which renders him/her unable to leave the home to obtain necessary medical care and treatment (i.e., is essentially homebound) or that the medical need for care at home is more appropriate and cost-effective and will prevent or delay institutionalization. Recipients do not need to be bedridden to be considered as having a medical need to receive care at home. Recipients may be considered eligible to receive care at home if they meet one or more of the following criteria:

(1) recipients who cannot leave their residences without the use of wheelchairs, crutches, walkers or assistance from another individual;

(2) recipients who because of severe physical or mental illness or injury must comply with doctor's orders and avoid all stressful physical activity;

(3) recipients who cannot leave their residences because of danger caused by a mental condition;

(4) recipients who have just returned to their residence after hospital stays for severe illness or surgical procedures and whose activities are restricted by their physicians because of pain, suffering, medical limitation or danger of infection.;

(5) recipients who are at high risk during pregnancy, infancy or childhood and for whom home health care is more appropriate to their needs.

(6) recipients are not eligible to receive care at home just because they:

(a) cannot drive,

(b) have multiple medical problems or

(c) live in an isolated area.

B. Infrequent periods away from residence: Recipients can leave their residences occasionally for medical treatment or personal errands and be eligible to receive home health care.

C. Determination of medical need to receive care at home: MAD or its designee reviews information submitted by the provider and determines whether recipients are considered eligible for home health service. Coverage is granted when the home health agency can demonstrate that care at home is appropriate to the medical needs of the recipient, the needed service is not otherwise available, and not receiving care would result in lack of access to health care services, institutionalization of the recipient and greater costs to the medicaid program.

D. Documentation of medical need to receive care at home: The home health agency is responsible for documenting on the written plan of care evidence of the recipient's medical need for home health care.

[8.325.9.12 NMAC - 8.325.9.12 NMAC, 7/1/2024]

8.325.9.13 COVERED SERVICES:

A. Medicaid covers those home health services which are skilled, intermittent and medically necessary. The focus of home health services shall be on the curative, restorative or preventive aspects of care. The goal of these services shall be to assist the recipient to return to an optimum level of functioning and to facilitate the timely discharge of the recipient to self-care or to care by their family, guardian or significant other. Services must be ordered by the recipient's attending physician and included in the plan of care established by the recipient's attending physician in consultation with home health agency staff. The plan of care must be reviewed, signed and dated by the attending physician. The attending physician certifies that the recipient has a medical need to receive care at home at the initial certification, and as part of the plan of care review at recertification. The attending physician certifies that the recipient requires the skilled services of a nurse, physical therapist, occupational therapist or speech therapist. If the recipient requires home health aide services, the physician shall certify the need for these services. The evaluation visit is covered whether or not the recipient is admitted to home health care. Covered services include the following:

(1) skilled nursing services;

(2) home health aide services;

(3) physical and occupational therapy services; and

(4) speech therapy services.

B. Skilled nursing services: Medicaid covers skilled, intermittent and medically necessary skilled nursing services if the following conditions are met:

(1) Services must be ordered by the attending physician and included in the plan of care established by the recipient's attending physician in consultation with the home health agency staff. The plan of care must be reviewed, signed and dated by the attending physician;

(2) Skills of a registered nurse or licensed practical nurse must be required for direct care or supervision of home health aides.

(3) Services must be furnished by or under the supervision of a registered nurse licensed in New Mexico who is responsible for the initial evaluation, care planning and coordination of services.

(4) Services must be reasonable and necessary to the treatment of an illness or injury. To be considered reasonable and necessary, the services furnished shall be:

(a) consistent with the recipient's particular medical needs as determined by the recipient's attending physician.

(b) consistent with accepted standards of medical and nursing practice.

(c) consistent with provision of care in the safest, least restrictive setting for meeting the recipient's needs.

(d) consistent with the New Mexico MAD approved medical necessity criteria for home health.

(5) Skilled nursing care includes, but is not limited to, the following:

(a) observation and evaluation of recipient's health needs

(b) teaching the recipient, family members or significant other caretaker to provide care such as, but not limited to:

(i) giving an injection;

(ii) irrigating a catheter;

(iii) providing wound care, including applying dressings to wounds, positioning, and recognizing signs of infection and other complications;

(iv) using medications properly and safely, and understanding potential side effects;

(v) using special equipment and adaptive devices; and

(vi) home safety.

(c) insertion and sterile irrigation of catheters;

(d) administering injections;

(e) administering intravenous antibiotics and enteral and intravenous total parenteral nutrition;

(f) treating decubitus ulcers and other skin disorders; and

(g) providing other health teaching according to recipient's needs.

C. Therapy services: Medicaid covers the therapy services furnished through the home health agency by licensed physical therapists, occupational therapists or speech language pathologists.

(1) Services must be ordered by the recipient's attending physician and included in the plan of care established by the attending physician in consultation with the home health agency staff.

(2) All therapy services must conform with practice standards and licensing requirements as defined by state law.

(3) Services can be furnished by a public, private for-profit or private non-profit home health agency directly or under arrangement.

D. Home health aide services: Medicaid covers home health aide services if the following conditions are met:

(1) home health aides must complete training or a competency evaluation program that meets certain requirements. See 42 CFR, Section 484.36;

(2) services must be ordered by the attending physician and included in the plan of care established by the recipient's attending physician in consultation with the home health agency staff;

(3) written instructions for patient care are prepared by a registered nurse or therapist;

(4) assignment to a particular recipient is made by a registered nurse;

(5) duties of the home health aide include:

(a) performance of simple procedures as an extension of nursing and therapy services;

(b) personal care;

(c) walking and exercises;

(d) household services essential to health care at home;

(e) help with medications that are normally self-administered;

(f) reporting changes in the recipient's condition; and

(g) completing appropriate records.

(6) registered nurses or other appropriate professional staff members must make a supervisory visit to the recipient's residence at least every two weeks to observe and decide whether goals are being met. The recipient's record must contain documentation that, at least every two weeks or more often if necessary, there has been communication between the home health aide and the supervisory nurse

or other appropriate professional staff member regarding the recipient's condition; and

(7) services must be furnished directly through the home health agency staff or by contractual arrangement.

E. Durable medical equipment and medical supplies: Medicaid covers medically necessary durable medical equipment and medical supplies which are specified in the plan of care. See 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies*.

(1) Reimbursement is made to the home health agency and is limited to medical supplies necessary during the course of the plan of care. The following durable medical equipment and medical supplies are covered as specified:

(a) Medicaid does not cover stock or routine items, such as band-aids, cotton balls, thermometers, lotion, personal care items, tape and alcohol.

(b) Non-routine supplies, such as catheters, ostomy supplies, feeding tubes, intravenous supplies, dressing supplies, ointments, solutions, chux diapers and home testing kits must be ordered as part of the plan of care.

(2) Utilization review, including retrospective review, can be made by MAD or its designee to assess the medical necessity for durable medical equipment and medical supplies and program compliance. If MAD determines that the equipment and supplies that were billed were not medically necessary or a covered service for the care of that recipient, the MAD payments are recouped.

F. Maternal/child services: Medicaid covers perinatal and pediatric home health services if the following conditions are met:

(1) the service is prescribed by the recipient's attending physician and is included in the plan of care established by the recipient's physician in consultation with home health agency staff;

(2) if the recipient has a medical need to receive care at home, in the sense that care in the home is more appropriate to the needs of the recipient, safe, cost-effective and will prevent or delay institutionalization;

(3) the services are reasonable and medically necessary to treat a high risk pregnancy, at-risk infant, illness, injury and to prevent infection. To be considered reasonable and medically necessary, the services furnished shall be:

(a) consistent with the recipient's particular medical needs as determined by the recipient's attending physician;

(b) consistent with accepted standards of medical and nursing practice;

(c) consistent with the New Mexico MAD approved medical necessity criteria for home health.

[8.325.9.13 NMAC - 8.325.9.13 NMAC, 7/1/2024]

8.325.9.14 NONCOVERED SERVICES: Home health services are subject to the limitations and coverage restrictions of other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*. Medicaid does not cover the following home health agency services:

A. services beyond the initial evaluation which are furnished without prior approval;

B. home health services which are not skilled, intermittent and medically necessary;

C. services furnished to recipients who do not meet the eligibility criteria for home health services;

D. services furnished to recipients in places other than their place of residence;

E. services furnished to recipients who reside in intermediate care facilities for the mentally retarded or nursing facility (NF) residents who require a high NF level of service. Physical, occupational and speech therapy can be furnished to residents of nursing facilities who require a low level of service.

F. skilled nursing services which are not supervised by registered nurses; and

G. services not included in written plans of care established by physicians in consultation with the home health agency staff.

[8.325.9.14 NMAC - 8.325.9.14 NMAC, 7/1/2024]

8.325.9.15 PRIOR APPROVAL AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Approval and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. Prior approval: All home health services beyond initial visits for evaluation purposes, require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process. Prior approval does not guarantee payment, if upon utilization review after payment has occurred, recipients are determined to be ineligible or medical necessity is not found.

B. Eligibility determination: Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior approval can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions*.

D. Effect of hospitalization: If a recipient is

hospitalized during the certification period and a significant change in condition or course of treatment occurs, the home health agency must treat the recipient as a new patient and submit a new prior approval request and new plan of care. If there is no significant change in the recipient's condition or course of treatment, an agency can resume care under the existing plan of care.
[8.325.9.15 NMAC - 8.325.9.15 NMAC, 7/1/2024]

8.325.9.16 [RESERVED]

8.325.9.17 REIMBURSEMENT: Home health agencies assume responsibility for any and all claims submitted on behalf of the provider and under the provider's number. Home health agencies must submit claims for reimbursement on the UB-92 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing. Reimbursement is made based on the Title XVIII (medicare) cost-finding procedures and reimbursement methodology. Charges are paid at an interim rate basis established under the medicaid guidelines by the medicare audit agent, subject to retroactive settlement when the cost report is final. Cost reports on appropriate forms must be submitted to the audit agent within 90 days of the close of the provider's fiscal accounting period. Failure to provide timely cost reports results in suspension of payments.
[8.325.9.17 NMAC - 8.325.9.17 NMAC, 7/1/2024]

8.325.9.18 REIMBURSEMENT LIMITATIONS: The following limitations apply to reimbursement made to home health agencies:

A. allowable costs are determined according to medicare and Title XIX (medicaid) reimbursement regulations;

B. the established percentage relationship of the agency's cost to charges per unity of services includes all services;

C. out-of-state providers are reimbursed at seventy percent of billed charges. Out-of-state home health services are approved only in very unusual circumstances, since home health services are furnished in the recipient's residence and that residence must be in New Mexico; and

D. claims for approved home health services must include the types of visits, dates of visits and number of visits.
[8.325.9.18 NMAC - 8.325.9.18 NMAC, 7/1/2024]

8.325.9.19 PLAN OF CARE:

A. The plan of care, established by the physician in consultation with the home health agency staff, and the request for prior approval must be received or postmarked within five working days of the proposed start of services or recertification period by MAD or its designee. Plans of care must be signed and dated by the physician, and prior approval must be received from MAD or its designee before claims are submitted to the MAD claims processing contractor. The plan of care must include the following:

(1) all principle diagnoses, surgical procedures, and other pertinent diagnoses;

(2) medications and dosages;

(3) types of services, equipment and non-routine supplies required;

(4) frequency of visits;

(5) safety measures to protect against injury;

(6) nutritional/fluid balance requirements;

(7) allergies;

(8) functional limitations, activities permitted and documentation of homebound status;

(9) mental status;

(10) prognosis;

(11) goals and measurable objectives, including rehabilitation potential, long range projection of likely changes in the recipient's condition and plans for timely discharge to self-care or to care by family, guardian or significant other; and

(12) Clinical findings and updates.

B. The plan of care for home health services is certified by MAD or its designee for specific time periods, not to exceed 62 working days.

C. The attending physician and home health agency professional personnel must review the total plan of care prior to a request for recertification and submit the revised plan, including a report on the patient's response to care provided under the previous plan of care and specifying changes in services required.
[8.325.9.19 NMAC - 8.325.9.19 NMAC, 7/1/2024]

HISTORY OF 8.325.9 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 310.0400, Home Health Agency Services, filed 2/18/1980.
MAD Rule 310.04, Home Health Services, filed 3/27/1992.

History of Repealed Material:
MAD Rule 310.04, Home Health Services, filed 3/27/1992 - Repealed effective 2/1/1995.
8 NMAC 4.MAD.768.7 Home Health Services Treatment Plan - Repealed effective 9/15/1997.
8.325.9 NMAC, Home Health Services Treatment Plan, filed 1/18/1995 - Repealed effective 7/1/2024.

Other: 8.325.9 NMAC, Home Health Services Treatment Plan, filed 1/18/1995 Replaced by 8.325.9 NMAC, Home Health Services Treatment Plan, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 325 SPECIALTY SERVICES
PART 10 EMERGENCY MEDICAL SERVICES FOR NON-CITIZENS

8.325.10.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.325.10.1 NMAC - Rp 8.325.10.1 NMAC, 7/1/2024]

8.325.10.2 SCOPE: The rule applies to the general public.
[8.325.10.2 NMAC - Rp 8.325.10.2 NMAC, 7/1/2024]

8.325.10.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under the Social Security Act as amended, or by state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.325.10.3 NMAC - Rp 8.325.10.3 NMAC, 7/1/2024]

8.325.10.4 DURATION: Permanent.
[8.325.10.4 NMAC - Rp 8.325.10.4 NMAC, 7/1/2024]

8.325.10.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.325.10.5 NMAC - Rp 8.325.10.5 NMAC, 7/1/2024]

8.325.10.6 OBJECTIVE: The objective of these rules is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.325.10.6 NMAC - Rp 8.325.10.6 NMAC, 7/1/2024]

8.325.10.7 DEFINITIONS: [**RESERVED**]

8.325.10.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico and to assure low income and individuals with disabilities in New Mexico equal participation in the life of their communities.
[8.325.10.8 NMAC - Rp 8.325.10.8 NMAC, 7/1/2024]

8.325.10.9 EMERGENCY MEDICAL SERVICES FOR NON-CITIZENS: The New Mexico MAD is required to pay for necessary emergency medical services furnished to individuals who are non-citizens, reside in New Mexico and meet the requirements for MAD eligibility 42 CFR 440.255(c).
[8.325.10.9 NMAC - Rp 8.325.10.9 NMAC, 7/1/2024]

8.325.10.10 ELIGIBLE PROVIDERS: Health care to eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HCA or its authorized agents obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only.
[8.325.10.10 NMAC - Rp 8.325.10.10 NMAC, 7/1/2024]

8.325.10.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to a medicaid or other health care program eligible recipient must comply with all federal and state laws, regulations, and executive orders relevant to the provision of services as specified in the MAD provider participation agreement. A provider also must conform to MAD program rules and instructions as specified in the provider rules manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services. When services are billed to and paid by a coordinated services contractor authorized by HCA, the provider must follow that contractor's instructions for billing and for authorization of services.

B. A provider may encourage an individual to apply for emergency medical services for non-citizens (EMSA) eligibility at a county office when the provider believes the service may qualify as an EMSA emergency service. A provider must inform the individual if the provider is unwilling to receive medicaid payment for the service when the service meets the EMSA emergency criteria for coverage. A provider must determine if the recipient has other health insurance. A provider must maintain records

that are sufficient to fully disclose the extent and nature of the services provided to a non-citizen recipient.
[8.325.10.11 NMAC - Rp 8.325.10.11 NMAC, 7/1/2024]

8.325.10.12 ELIGIBLE INDIVIDUALS:

A. An applicant must be a noncitizen who is undocumented or who does not meet the qualifying immigration criteria specified in 8.200.410 NMAC, *General Recipient Requirements,* and in 8.285.400 NMAC, *Medicaid Eligibility-Emergency Medical Services for Non-Citizens-Category 085.*

B. Eligibility determinations are made by local county income support division (ISD) offices after the receipt of emergency services. The individual is responsible for completing an application at the local county ISD office and for providing all necessary documentation to prove that they meet the applicable eligibility criteria.

(1) An individual must apply for coverage at the ISD office no later than the last day of the third month following the month in which the alleged emergency services were received.

(2) A non-citizen recipient is responsible for notifying providers of the approval or denial of an application.

(3) If an application is denied or an application for coverage is not filed by the last day of the third month following the month in which the alleged emergency services were received, the non-citizen recipient is responsible for payment of the provider bill.

(4) If reimbursement for services is denied by MAD, the individual is responsible for payment and can be billed directly for payment by the provider.
[8.325.10.12 NMAC - Rp 8.325.10.12 NMAC, 7/1/2024]

8.325.10.13 COVERAGE CRITERIA:

A. "Emergency" as defined for EMSA includes labor and delivery including inductions and cesarean sections, as well as any other medical condition, manifesting itself with acute symptoms of sufficient severity such that the absence of immediate emergency medical attention could reasonably be expected to result in one of the following:

(1) the non-citizen recipient's death;

(2) placement of the non-citizen recipient's health in serious jeopardy;

(3) serious impairment of bodily functions; or

(4) serious dysfunction of any bodily organ or part.

B. Services are covered only when necessary to treat or evaluate a condition meeting the definition of emergency and are covered only for the duration of that emergency.

C. After delivery, a child can have legally documented or citizenship status because of its birth in the United States and, therefore, is not eligible for emergency services for non-citizens. The child may be eligible for another MAD category of eligibility on their own.

D. Determination of coverage is made by MAD or its designee.
[8.325.10.13 NMAC - Rp 8.325.10.13 NMAC, 7/1/2024]

8.325.10.14 SERVICE LIMITATIONS: To meet the categorical eligibility requirements, a recipient who is a non-citizen must be a resident of the state of New Mexico. Proof of residence must be furnished by the non-citizen to the local county ISD office. An individual traveling through New Mexico, entering the United States through New Mexico en route to another destination, visiting in New Mexico or touring New Mexico with a tourist visa does not meet the residence requirement.
[8.325.10.14 NMAC - Rp 8.325.10.14 NMAC, 7/1/2024]

8.325.10.15 NONCOVERED SERVICES: MAD does not cover any medical service that is not necessary to treat or evaluate a condition for an individual who is a non-citizen that does not meet the definition of emergency. Additionally, MAD does not cover the following specific services:

A. long term care;

B. organ transplants;

C. rehabilitation services;

D. elective surgical procedures;

E. psychiatric or psychological services;

F. durable medical equipment or supplies;

G. eyeglasses;

H. hearing aids;

I. outpatient prescriptions;

J. podiatry services;

K. prenatal and postpartum care;

L. well child care;

M. routine dental care;

N. routine dialysis services;

O. any medical service furnished by an out-of-state provider;

P. non-emergency transportation; and

Q. preventive care.
[8.325.10.15 NMAC - Rp 8.325.10.15 NMAC, 7/1/2024]

8.325.10.16 UTILIZATION REVIEW: Claims for services to a recipient who is a non-citizen are reviewed by MAD or its designee before payment to determine if the circumstances warrant coverage.

A. Eligibility determination: A non-citizen recipient who requests MAD coverage for services must meet specific categorical eligibility requirements. Eligibility determinations by local county ISD offices must be made before the review for medical necessity.

B. Reconsideration: A provider and the non-citizen are given notice of the denial when the EMSA emergency criteria are not met. A non-citizen recipient can request a re-review and reconsideration of denied coverage of the service. See

8.350.2 NMAC, *Reconsideration of Utilization Review Decisions*. A non-citizen recipient can also request a hearing. See 8.52.2 NMAC, *Recipient Hearings*.
[8.325.10.16 NMAC - Rp 8.325.10.16 NMAC, 7/1/2024]

8.325.10.17 REIMBURSEMENT: Reimbursement is made according to the rules applicable to the provider rendering the service.
[8.325.10.17 NMAC - Rp 8.325.10.17 NMAC, 7/1/2024]

HISTORY OF 8.325.10 NMAC:
[**RESERVED**]

History of Repealed Material:
8.325.10 NMAC, Emergency Medical Services For Aliens, filed 11/14/2003 - Repealed effective 7/1/2024.

Other: 8.325.10 NMAC, Emergency Medical Services For Aliens, filed 11/14/2003 Replaced by 8.325.10 NMAC, Emergency Medical Services For Aliens, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 326 CASE MANAGEMENT SERVICES
PART 2 CASE MANAGEMENT SERVICES FOR ADULTS WITH DEVELOPMENTAL DISABILITIES

8.326.2.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.326.2.1 NMAC - Rp 8.326.2.1 NMAC, 7/1/2024]

8.326.2.2 SCOPE: The rule applies to the general public.
[8.326.2.2 NMAC - Rp 8.326.2.2 NMAC, 7/1/2024]

8.326.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Sections 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.326.2.3 NMAC - Rp 8.326.2.3 NMAC, 7/1/2024]

8.326.2.4 DURATION: Permanent.
[8.326.2.4 NMAC - Rp 8.326.2.4 NMAC, 7/1/2024]

8.326.2.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.326.2.5 NMAC - Rp 8.326.2.5 NMAC, 7/1/2024]

8.326.2.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.326.2.6 NMAC - Rp 8.326.2.6 NMAC, 7/1/2024]

8.326.2.7 DEFINITIONS:
[**RESERVED**]

8.326.2.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.326.2.8 NMAC - Rp 8.326.2.8 NMAC, 7/1/2024]

8.326.2.9 CASE MANAGEMENT SERVICES FOR ADULTS WITH DEVELOPMENTAL DISABILITIES: The New Mexico medical assistance program (medicaid) pays for medically necessary health services furnished to eligible recipients, including covered case management services furnished to adult recipients who have developmental disabilities [42 U.S.C. Section 1396n(g)(1)(2)]. This part describes eligible providers, eligible recipients, covered services, service limitations and general reimbursement methodology.
[8.326.2.9 NMAC - Rp 8.326.2.9 NMAC, 7/1/2024]

8.326.2.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), the following agencies are eligible to be reimbursed for providing case management services:

(1) state agencies in New Mexico providing case management services to individuals with developmental disabilities;

(2) Indian tribal governments and Indian health service clinics; and

(3) community-based agencies in New Mexico that do not furnish adult day habilitation, work related services, or adult residential services to individuals with developmental disabilities.

B. Agency qualification: Agencies must be certified by the developmental disabilities division of the HCA and meet the MAD approved standards for agencies providing case management for adults who are developmentally disabled.

(1) Agencies must demonstrate knowledge of the community to be served, its populations and its resources, including methods for accessing those resources.

(2) Agencies must demonstrate direct experience in case management services

and success in serving the target population.

(3) Agencies must have personnel management skills, including written policies and procedures that include recruitment, selection, retention and termination of case managers, job descriptions for case managers, grievance procedures, hours of work, holidays, vacations, leaves of absence, wage scales and benefits, conduct and other general rules.

C. Case manager qualifications: Case managers employed by case management agencies must possess the education, skills, abilities and experience to perform case management service for adults with developmental disabilities. At a minimum, case managers must meet one of the following qualifications:

(1) bachelor's degree from an accredited institution in a human services field or any related academic discipline associated with the study of human behavior or human skills development, such as psychology, sociology, speech, gerontology, education, counseling, social work, human development or any other study of services related field and one (1) year of experience working with individuals with developmental disabilities;

(2) licensed as a registered or licensed practical nurse with one year of experience working with individuals with developmental disabilities; or

(3) In the event that there are no suitable candidates with the above qualifications, individuals with the following qualifications and experience can be employed as case managers:

(a) associate's degree and a minimum of three years of experience working with individuals with developmental disabilities; or

(b) high school graduation or general educational development (GED) test and a minimum of four (4) years of experience working with individuals with developmental disabilities.

(4) Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[8.326.2.10 NMAC - Rp 8.326.2.10 NMAC, 7/1/2024]

8.326.2.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, General Provider Policies. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC, General Provider Policies. Documentation must substantiate the date of service, type of contact, category of case management service furnished, length/time units of service furnished, nature/content of the service furnished, result of service or intended result and relationship of the service furnished to goals identified in the plan of care.

[8.326.2.11 NMAC - Rp 8.326.2.11 NMAC, 7/1/2024]

8.326.2.12 ELIGIBLE RECIPIENTS:

A. Case management services are available for eligible medicaid recipients that meet all of the following criteria:

(1) 21 years of age or older;

(2) resident of the state of New Mexico;

(3) meet the state definition of an individual with a developmental disability;

(4) placement on the list for developmental disability services by the community services team (CST) of the developmental disabilities division of the HCA;

(5) resides outside a medicaid certified intermediate care facility for the mentally retarded (ICF-MR); and

(6) not a participant in a home and community-based services waiver program.

B. Information on the individual is gathered by the CST and used to complete an assessment and assign an "urgency of need" priority. Recipients assigned a priority one are individuals who are in danger of becoming homeless or victims of abuse, if suitable placement services are not received. Recipients assigned a priority two are individuals whose condition will deteriorate without placement. Recipients assigned a priority three are individuals who could benefit from case management but whose present condition is acceptable.

[8.326.2.12 NMAC - Rp 8.326.2.12 NMAC, 7/1/2024]

8.326.2.13 COVERED SERVICES: Medicaid coverage for case management services varies by the priority assigned recipients by the CST.

A. Case management services for recipients assigned a priority three: Case management services for recipients assigned a priority three are limited. Medicaid covers assessments of recipients' needs and the coordination and performance of evaluations and assessments. A follow-up is performed during the third month with appropriate recommendations. Medicaid covers case management services for recipients classified as priority three only for an initial 90 day period, unless the recipient's urgency of need priority changes to priority one or priority two.

B. Case management services for recipients assigned priority one or priority two: Medicaid covers case management services for those recipients assigned a priority

one or priority two for up to 60 days after suitable placement or services are received. Medicaid covers the following case management service activities for these recipients:

(1) assessment of the recipient's medical and social needs and functional limitations;

(2) coordination and monitoring of evaluations and services;

(3) help in identifying available service providers and programs to enhance the recipient's community access and involvement, including:

(a) arrangement of transportation;

(b) location of housing;

(c) location of providers to teach living skills;

(d) location of vocational or educational services; and

(e) location of civic or recreational services, as needed.

(4) facilitation and participation in the development, review and evaluation of a plan of care and revision of that plan when warranted; and

(5) assessment of the recipient's progress and continued need for services.

C. Administrative activities: Medicaid eligibility determinations or intake processing are covered services for individuals with developmentally disabilities who have not applied for medicaid but who have been referred to the CST for evaluation. These administrative services are billed as administrative activities, not as case management services.

[8.326.2.13 NMAC - Rp 8.326.2.13 NMAC, 7/1/2024]

8.326.2.14 NONCOVERED SERVICES: Case management services are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, General Noncovered Services. Medicaid does not cover the following specific activities:

A. services furnished to individuals who are not medicaid eligible or do not meet the definition of an eligible recipient for these case management services;

B. services furnished by case managers which are not substantiated with appropriate documentation in the recipient's file;

C. formal educational or vocational services which relate to traditional academic subjects or job training;

D. outreach activities to contact potential recipients, except as described under covered services;

E. all administrative activities conducted after the initial 90 day referral by the CST;

F. institutional discharge planning which must be furnished by the institution prior to discharge;

G. services which are furnished under other categories, such as therapies, transportation or counseling;

H. services which are considered by MAD or its designee to be excessive based on the condition of the recipient;

I. monitoring the quality of service provider agencies;

J. resource development; and

K. testifying before governmental bodies, such as city council meetings or legislative committees, even if on behalf of the recipient.

[8.326.2.14 NMAC - Rp 8.326.2.14 NMAC, 7/1/2024]

8.326.2.15 PLAN OF CARE:

A. Case managers develop and implement plans of care (POC) based on standards developed by the developmental disabilities division of the HCA. For purposes of compliance with medicaid regulations, the following must be contained in the plan of care or documents used to develop the plan of care. The plan of care and supporting documents must be available for review in the recipient's file:

(1) statement of the nature of the specific problem and needs of the recipient;

(2) description of the functional level of the recipient, including an assessment and evaluation of the following:

(a) mental status assessment;

(b) intellectual function assessment;

(c) psychological assessment;

(d) educational assessment;

(e) vocational assessment;

(f) social assessment;

(g) medication assessment; and

(h) physical assessment.

(3) description of the intermediate and long-range goals and placement options with the projected timetable for their attainment, including information on the duration and scope of services; and

(4) statement and rationale of the plan of treatment for achieving these intermediate and long-range goals, including review and modification of the plan.

B. The plan of care must be retained by agency providers and available for utilization review purposes. Plans of care must be updated and revised, as indicated, at least every six months or more often, as indicated by the recipient's condition.

[8.326.2.15 NMAC - Rp 8.326.2.15 NMAC, 7/1/2024]

8.326.2.16 PRIOR APPROVAL AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, Prior Approval and Utilization Review. Once enrolled, providers receive instructions and

documentation forms necessary for prior approval and claims processing.

A. Prior approval: Certain procedures or services which are part of the recipients' plan of care can require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See 8.350.2 NMAC, Reconsideration of Utilization Review Decisions.
[8.326.2.16 NMAC - Rp 8.326.2.16 NMAC, 7/1/2024]

8.326.2.17 REIMBURSEMENT:

A. Case management providers must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See 8.302.2 NMAC, Billing for Medicaid Services. Instructions on documentation, billing and claims processing are sent to approved medicaid providers. Reimbursement for covered case management services is made at the lesser of the following:

(1) the provider's billed charge; or

(2) the MAD fee schedule for the specific service or procedure.

B. The provider's billed charge must be their usual and customary charge for an average month of services to individuals who are part of the target population. Monthly charges are based on a cost analysis conducted periodically by the HCA.

C. "Usual and customary charge" refers to the amount which the individual providers charge the general public in the majority of cases for a specific procedure or service.

D. For case management services furnished by an institution, costs associated with case management must be removed from their cost reports prior to cost settlement or rebasing.
[8.326.2.17 NMAC - Rp 8.326.2.17 NMAC, 7/1/2024]

HISTORY OF 8.326.2 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
MAD Rule 310.33, Case Management Services for Adults with Developmental Disabilities, filed 5/21/1991.
MAD Rule 310.33, Case Management Services for Adults with Developmental Disabilities, filed 3/10/1994.

History of Repealed Material:
8.326.2 NMAC, Case Management Services for Adults with Developmental Disabilities, filed 1/18/1995 Repealed effective 7/1/2024.

Other: 8.326.2 NMAC, Case Management Services for Adults with Developmental Disabilities, filed 1/18/1995 Replaced by 8.326.2 NMAC, Case Management Services for Adults with Developmental Disabilities, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 349 COORDINATED SERVICE CONTRACTORS
PART 2 APPEALS AND GRIEVANCE PROCESS

8.349.2.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.349.2.1 NMAC - Rp 8.349.2.1 NMAC, 7/1/2024]

8.349.2.2 SCOPE: The rule applies to the general public.
[8.349.2.2 NMAC - Rp 8.349.2.2 NMAC, 7/1/2024]

8.349.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.349.2.3 NMAC - Rp 8.349.2.3 NMAC, 7/1/2024]

8.349.2.4 DURATION: Permanent.
[8.349.2.4 NMAC - Rp 8.349.2.4 NMAC, 7/1/2024]

8.349.2.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.349.2.5 NMAC - Rp 8.349.2.5 NMAC, 7/1/2024]

8.349.2.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.349.2.6 NMAC - Rp 8.349.2.6 NMAC, 7/1/2024]

8.349.2.7 DEFINITIONS: [**RESERVED**]

8.349.2.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment

for quality health services at levels comparable to private health plans.
[8.349.2.8 NMAC - Rp 8.349.2.8 NMAC, 7/1/2024]

8.349.2.9 COORDINATED SERVICE CONTRACTORS (CSC): CSCs that manage some services of the medicaid program are responsible for any or all aspects of program management, prior authorization, utilization review, claims processing, and issuance of remittance advices and payments.

A. The CSC shall have a grievance system in place for recipients that include a grievance process related to dissatisfaction and an appeals process related to a CSC's action, including the opportunity to request an HCA fair hearing.

B. A grievance is a recipient's expression of dissatisfaction about any matter or aspect of the CSC or its operation, other than a CSC's action, as defined below.

C. An appeal is a request for review by the CSC of a CSC's action. An action is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure to provide services in a timely manner. An untimely service authorization constitutes a denial and is thus considered an action.

D. The recipient, legal guardian of the recipient for a minor or an incapacitated adult, or a representative of the recipient as designated in writing to the CSC, has the right to file a grievance or an appeal of the CSC's action on behalf of the recipient. A provider acting on behalf of the recipient, with the recipient's written consent, may file a grievance or an appeal of a CSC's action.

E. In addition to the CSC's grievance and appeal process described above, a recipient, legal guardian of the recipient for a minor or an incapacitated adult, or the representative of the recipient has the right to request a fair hearing on behalf of the recipient with HCA directly as described in 8.352.2 NMAC, *Recipient Hearings*, if a CSC's decision results in termination, modification, suspension, reduction, or denial of services to the recipient or if the recipient believes the CSC has taken an action erroneously. A fair hearing may be requested prior to, concurrent with, subsequent to, or in lieu of a grievance or appeal to the CSC.
[8.349.2.9 NMAC - Rp 8.349.2.9 NMAC, 7/1/2024]

8.349.2.10 GENERAL REQUIREMENTS FOR GRIEVANCE AND APPEALS:

A. The CSC shall implement written policies and procedures describing how the recipient may submit a request for a grievance or an appeal with the CSC or submit a request for a fair hearing with the HCA. The policy shall include a description of how the CSC resolves the grievance or appeal.

B. The CSC shall provide to all service providers and subcontractors in the CSC's network a written description of the CSC's grievance and appeal process and how the provider can submit a grievance or appeal.

C. The CSC shall have available reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

D. The CSC shall name a specific individual(s) designated as the CSC's medicaid recipient grievance coordinator with the HCA to administer the policies and procedures for resolution of a grievance or an appeal, to review patterns/trends in grievances or appeals, and to initiate corrective action.

E. The CSC shall ensure that the individuals that make the decisions on grievances or appeals are not involved in any previous level of review or decision-making. The CSC shall also ensure that health care professionals with appropriate clinical expertise shall make decisions for the following:

(1) an appeal of a CSC denial that is based on lack of medical necessity;

(2) a CSC denial that is upheld in an expedited resolution;

(3) a grievance or appeal that involves clinical issues.

F. Upon enrollment, the CSC shall provide recipients, at no cost, with an 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 recipient information shall also advise recipients of their right to file a request for an administrative hearing with the HCA hearings bureau, upon notification of a CSC action, or concurrent with or following an appeal of the CSC action.

G. The CSC shall ensure that punitive or retaliatory action is not taken against a recipient or a provider that files a grievance or an appeal, or a provider that supports a recipients' grievance or appeal.
[8.349.2.10 NMAC - Rp 8.349.2.10 NMAC, 7/1/2024]

8.349.2.11 GRIEVANCE: A grievance is a recipient's expression of dissatisfaction about any matter or aspect of the CSC or its operation.

A. A recipient may file a grievance either orally or in writing with the CSC within 90 calendar days of the date the event causing the dissatisfaction occurred. The legal guardian of the recipient for a minor or an incapacitated adult, a representative of the recipient as designated in writing to the CSC, and a provider acting on behalf of the recipient and with the recipient's written consent, have the right to file a grievance on behalf of the recipient.

B. Within five working days of receipt of the grievance, the CSC 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 CSC resolution process for grievances shall be completed within 30 calendar days of the date the grievance is received by the CSC and shall include a resolution letter to the grievant or the grievant' s representative.

D. The CSC may request an extension from HCA up to 14 calendar days if the grievant requests the extension, or the CSC demonstrates to HCA that there is need for additional information, and the extension is in the recipient's interest. For any extension not requested by the grievant, the CSC shall give the grievant 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 CSC shall mail a resolution letter to the grievant, legal guardian, representative, and provider acting on behalf of the recipient. 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.

[8.349.2.11 NMAC - Rp 8.349.2.11 NMAC, 7/1/2024]

8.349.2.12 APPEALS: An appeal is a request for review by the CSC of a CSC action.

A. An action is defined as:

(1) the denial or limited authorization of a requested service, including the type of 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 CSC to provide services in a timely manner, as defined by HCA; or

(5) the failure of the CSC to complete the authorization request in a timely manner as defined in 42 CFR 438.408.

B. The CSC shall mail a notice of action to the recipient and provider within 10 days of the date of the action, except for denial of claims that may result in recipient financial liability, which requires immediate notification. The notice shall contain, but not be limited, to the following:

(1) the action CSC has taken or intends to take;

(2) the reasons for the action;

(3) the recipient's or the provider's right to file an appeal of the CSC action through the CSC;

(4) the recipient's right to request an HCA 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 recipient's right to have benefits continue pending resolution of an appeal, how to request the continuation of benefits, and the circumstances under which the recipient may be required to pay the costs of continuing these benefits.

C. A recipient may file an appeal of a CSC action within 90-calendar days of receiving the CSC's notice of action. The legal guardian of the recipient for a minor or an incapacitated adult, a representative of the recipient as designated in writing to the CSC, or a provider acting on behalf of the recipient with the recipient's written consent, have the right to file an appeal of an action on behalf of the recipient.

D. The CSC has 30-calendar days from the date the initial oral or written appeal is received by the CSC to resolve the appeal.

E. The CSC shall have a process in place that ensures that an oral or written inquiry from a recipient seeking to appeal an action is treated as an appeal (to establish the earliest possible filing date for the appeal). The CSC shall use its best efforts to assist recipients as needed with the written appeal.

F. Within five working days of receipt of the appeal, the CSC shall provide the grievant with written notice that the appeal has been received and the expected date of its resolution. The CSC shall confirm in writing receipt of oral appeals, unless the recipient or the provider requests an expedited resolution.

G. The CSC may extend the 30 days time frame by 14 calendar days if the recipient requests the extension, or the CSC demonstrates to HCA that there is need for additional information, and the extension is in the recipient's interest. For any extension not requested by the recipient, the CSC shall give the recipient written notice of the extension and the reason for the extension within two working days of the decision to extend the time frame.

H. The CSC shall provide the recipient or the recipient's representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing.

I. The CSC shall provide the recipient or the representative the opportunity, before and during the appeals process, to examine recipient's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the appeals process. The CSC shall include as parties to the appeal the recipient and their representative, or the legal representative of a deceased recipient's estate.

J. For all appeals, the CSC shall provide written notice within the 30-calendar-day timeframe for resolution to the grievant, legal guardian, representative, and provider acting on behalf of the recipient.

(1) The written notice of the appeal resolution

shall include, but not be limited to, the following information:

(a) the results of the appeal resolution; and

(b) the date it was completed.

(2) The written notice of the appeal resolution for appeals not resolved wholly in favor of the recipient shall include, but not be limited to, the following information:

(a) the right to request an HCA 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 recipient may be held liable for the cost of continuing benefits if the hearing decision upholds the CSC's action.

K. The CSC may continue benefits while the appeal or the HCA fair hearing process is pending.

(1) The CSC shall continue the recipient's benefits if all of the following are met:

(a) the recipient or the provider files a timely appeal of the CSC action within 10 days of the date on the notice of action from the CSC);

(b) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment:

(c) the services are ordered by an authorized provider;

(d) the recipient requests extension of benefits.

(2) The CSC shall provide benefits until one of the following occurs:

(a) the recipient withdraws the appeal;

(b) 10 days have passed since the date of the resolution letter, provided the resolution of the appeal was against the recipient and the recipient has taken no further action;

(c) HCA issues a hearing decision adverse to the recipient;

(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 recipient, that is, the CSC's action is upheld, the CSC 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 CSC or HCA reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending the CSC shall authorize or provide the disputed services promptly and as expeditiously as the recipient's health condition requires.

(5) If the CSC or HCA reverses a decision to deny, limit or delay services and the recipient received the disputed services while the appeal was pending, the CSC shall pay for these services.

[8.349.2.12 NMAC - Rp 8.349.2.12 NMAC, 7/1/2024]

8.349.2.13 EXPEDITED RESOLUTION OF APPEALS: An expedited resolution of an appeal is an expedited review by the CSC of a CSC action.

A. The CSC shall establish and maintain an expedited review process for appeals when the CSC determines that allowing the time for a standard resolution could seriously jeopardize the recipient's life or health or ability to attain, maintain, or regain maximum function. Such a determination is based on:

(1) a request from the recipient;

(2) a provider's support of the recipient's request;

(3) a provider's request on behalf of the recipient; or

(4) the CSC's independent determination.

B. The CSC shall ensure that the expedited review process is convenient and efficient for the recipient.

C. The CSC 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 8.349.2.13 NMAC.

D. The CSC may extend the time frame by up to 14 calendar days if the recipient requests the extension, or the CSC demonstrates to HCA that there is need for additional information and the extension is in the recipient's interest. For an extension not requested by the recipient, the CSC shall give the recipient written notice of the reason for the delay.

E. The CSC shall ensure that punitive action is not taken against a recipient or a provider who requests an expedited resolution or supports a recipient's expedited appeal.

F. The CSC 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 recipient or provider on behalf of the recipient.

G. The CSC shall inform the recipient of the limited time available to present evidence and allegations in fact or law.

H. If the CSC 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 CSC received the original request for appeal;

(2) make reasonable efforts to give the recipient prompt oral notice of the denial, and follow up with a written notice within two calendar days; and

(3) inform the grievant in the written notice of the right to file an appeal or request an HCA fair hearing if the recipient is dissatisfied with the CSC's decision to deny an expedited resolution.

I. The CSC shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.

[8.349.2.13 NMAC - Rp 8.349.2.13 NMAC, 7/1/2024]

8.349.2.14 SPECIAL RULE FOR CERTAIN EXPEDITED SERVICE AUTHORIZATION DECISIONS: In the case of expedited service authorization decisions that deny or limit services, the CSC shall, within 72 hours of receipt of the request for service, automatically file an appeal on behalf of the recipient, use its best effort, to give the recipient oral notice of the decision on the automatic appeal and to resolve the appeal.

[8.349.2.14 NMAC - Rp 8.349.2.14 NMAC, 7/1/2024]

8.349.2.15 OTHER RELATED COORDINATED SERVICE CONTRACTOR (CSC) PROCESSES:

A. Information about grievance system to providers and subcontractors: The CSC shall provide information specified in 42 CFR438.10(g) (1) about the grievance system to all providers and subcontractors at the time that 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 accessible to HCA, upon request, for review. Grievance or appeal files shall be retained for six years following the final decision by the CSC, HCA, and administrative law judge, judicial appeal, or closure of a file, whichever occurs later.

(2) The CSC 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 recipient of receipt of the grievance or appeal, all correspondence between the CSC and the recipient, the date the grievance or appeal is resolved, the resolution, the notices of final decision to the recipient, and all other pertinent information.

(3) Documentation regarding the grievance shall be made available to the grievant, legal guardian representative, or provider acting on behalf of the recipient if requested.

[8.349.2.15 NMAC - Rp 8.349.2.15 NMAC, 7/1/2024]

8.349.2.16 COORDINATED SERVICE CONTRACTOR (CSC) PROVIDER GRIEVANCE PROCESS: The CSC shall establish and maintain written policies and procedures for the filing of provider grievances. A provider shall have the right to file a grievance with the CSC regarding utilization management decisions or provider payment issues. Grievances shall be resolved within 30 calendar days. A provider may not file a grievance on behalf of a recipient without written designation by the recipient as the recipient's representative. See 8.349.2.14 NMAC for special rules for certain expedited service authorizations.

[8.349.2.16 NMAC - Rp 8.349.2.16 NMAC, 7/1/2024]

History of 8.349.2 NMAC: [**RESERVED**]

History of Repealed Material: 8.49.2 NMAC,Appeals And Grievance Process, filed 12/13/2006 - Repealed effective 7/1/2024.

Other: 8.349.2 NMAC,Appeals And Grievance Process, filed 12/13/2006 Replaced by 8.349.2 NMAC,Appeals And Grievance Process, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

For all rules being amended in Title 8 by the Human Services Department, the following explanatory statements apply to all rules:

Consistent with all other rules converted from the Human Services Department to the Health Care Authority, throughout this rule, if found: "department" is changed to "authority" or "HCA"; "HSD" is changed to "HCA" and that acronym is first introduced in the third section of the rule; "alien" is changed to "non-citizen"; "child support enforcement division" is changed to "child support services division"; "CSED" is changed to "CSSD"; and style and formatting have been updated to conform with current NM State Records Center guidelines.

Wherever found throughout all of the amended rules, "he/she" or any other gender specific reference is changed to a "they/them" or a gender-neutral reference; and any remnant style and formatting (as to citation, punctuation, etc....) will get updated to conform with current ALD style and language guidelines.

This is an amendment to 8.1.2 NMAC, Sections 1 & 3, effective 7/1/2024.

8.1.2.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority

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

8.1.2.3 STATUTORY AUTHORITY:

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

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

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.1.2.3 NMAC - N, 11/01/2018; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.50.100 NMAC, Sections 1 & 3, effective 7/1/2024.

8.50.100.1 ISSUING AGENCY: [~~New Mexico Human Services Department - Child Support Enforcement Division~~.] New Mexico Health Care Authority - Child Support Services Division.
[8.50.100.1 NMAC - Rp, 8.50.100.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.100.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The [~~human services department~~] health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.100.3 NMAC - Rp, 8.50.100.3 NMAC, 12/30/2010; A, 1/1/2022; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.50.108 NMAC, Sections 1 & 3, effective 7/1/2024.

8.50.108.1 ISSUING AGENCY: [~~New Mexico Human Services Department - Child Support Enforcement Division~~] New Mexico Health Care Authority - Child Support Services Division.
[8.50.108.1 NMAC - Rp, 8.50.108.1 NMAC, 1/1/2024; A, 7/1/2024]

8.50.108.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The [~~human services department~~] health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.108.3 NMAC - Rp, 8.50.108.3 NMAC, 1/1/2024; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.50.109 NMAC, Sections 1 & 3, effective 7/1/2024.

8.50.109.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.50.109.1 NMAC - Rp, 8.50.109.1 NMAC 1/1/2024; A, 7/1/2024]

8.50.109.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The [~~human services department~~] health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.) Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.109.3 NMAC - Rp, 8.50.109.3 NMAC 1/1/2024; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.50.110 NMAC, Sections 1 & 3, effective 7/1/2024.

8.50.110.1 ISSUING AGENCY: [~~New Mexico Human Services Department - Child Support Enforcement Division~~.] New Mexico Health Care Authority - Child Support Services Division.
[8.50.110.1 NMAC - Rp, 8.50.110.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.110.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The [~~human services department~~] health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.110.3 NMAC - Rp, 8.50.110.3 NMAC, 12/30/2010; A, 1/1/2022; A 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.50.111 NMAC, Sections 1 & 3, effective 7/1/2024.

8.50.111.1 ISSUING AGENCY: [~~New Mexico Human Services Department - Child Support Enforcement Division~~] New Mexico Health Care Authority - Child Support Services Division.
[8.50.111.1 NMAC - Rp, 8.50.111.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.111.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The[~~human services department~~] health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.111.3 NMAC - Rp, 8.50.111.3 NMAC, 12/30/2010; A, 1/1/2022; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.50.112 NMAC, Sections 1 & 3, effective 7/1/2024.

8.50.112.1 ISSUING AGENCY: [~~New Mexico Human Services Department - Child Support Enforcement Division~~] New Mexico Health Care Authority - Child Support Services Division.
[8.50.112.1 NMAC - Rp, 8.50.112.1 NMAC, 12/30/2010; A, 71/2024]

8.50.112.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 et. seq., NMSA 1978. The [~~human services department~~] health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.112.3 NMAC - Rp, 8.50.112.3 NMAC, 12/30/2010; A, 1/1/2022, A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.50.113 NMAC, Sections 1 & 3, effective 7/1/2024.

8.50.113.1 ISSUING AGENCY: [~~New Mexico Human Services Department - Child Support Enforcement Division~~] New Mexico Health Care Authority - Child Support Services Division.
[8.50.113.1 NMAC - Rp, 8.50.113.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.113.3 STATUTORY AUTHORITY: Public Assistance Act, NMSA 1978, Section 27-2-27. The [~~human services department~~] health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.113. 3 NMAC - Rp, 8.50.113.3 NMAC, 12/30/2010; A, 7/1/2024]

This is an amendment to 8.50.114 NMAC, Sections 1 & 3, effective 7/1/2024.

8.50.114.1 ISSUING AGENCY: [~~New Mexico Human Services Department - Child Support Enforcement Division~~] New Mexico Health Care Authority - Child Support Services Division.
[8.50.114.1 NMAC - Rp, 8.50.114.1 NMAC, 12/30/2010; A,7/1/2024]

8.50.114.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The [~~human services department~~] health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.114.3 NMAC - Rp, 8.50.114.3 NMAC, 12/30/2010; A, 1/1/2022; A,7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.50.115 NMAC, Sections 1 & 3, effective 7/1/2024.

8.50.115.1 ISSUING AGENCY: [~~New Mexico Human Services Department - Child Support Enforcement Division~~] New Mexico Health Care Authority - Child Support Services Division.
[8.50.115.1 NMAC - Rp, 8.50.115.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.115.3 STATUTORY AUTHORITY: Public Assistance Act, NMSA 1978, Section 27-2-27. The [~~human services department~~] health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.115.3 NMAC - Rp, 8.50.115.3 NMAC, 12/30/2010; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.50.117 NMAC, Sections 1 & 3, effective 7/1/2024.

8.50.117.1 ISSUING AGENCY: [~~New Mexico Human Services Department - Child Support Enforcement Division~~] New Mexico Health Care Authority - Child Support Services Division.
[8.50.117.1 NMAC - Rp, 8.50.117.1 NMAC, 12/30/2010; A, 7/1/2/024]

8.50.117.3 STATUTORY AUTHORITY: Public Assistance Act, NMSA 1978, Section 27-2-27. The [~~human services department~~] health care authority - child support division is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.117.3 NMAC - Rp, 8.50.117.3 NMAC, 12/30/2010; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.50.124 NMAC, Sections 1 & 3, effective 7/1/2024.

8.50.124.1 ISSUING AGENCY: [~~New Mexico Human Services Department - Child Support Enforcement Division~~] New Mexico Health Care Authority - Child Support Services Division.
[8.50.124.1 NMAC - Rp, 8.50.124.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.124.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 NMSA 1978. The [~~human services department~~] health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.124.3 NMAC - Rp, 8.50.124.3 NMAC, 12/30/2010; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.50.125 NMAC, Sections 1 & 3, effective 7/1/2024.

8.50.125.1 ISSUING AGENCY: [~~New Mexico Human Services Department - Child Support Enforcement Division~~] New Mexico Health Care Authority - Child Support Services Division.
[8.50.125.1 NMAC - Rp, 8.50.125.1 NMAC, 9/1/2022; A,7/1/2024]

8.50.125.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The [~~human services department~~] health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.125.3 NMAC - Rp, 8.50.125.3 NMAC, 9/1/2022; A,7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.50.129 NMAC, Sections 1 & 3, effective 7/1/2024.

8.50.129.1 ISSUING AGENCY: [~~New Mexico Human Services Department - Child Support Enforcement Division~~] New Mexico Health Care Authority - Child Support Services Division.
[8.50.129.1 NMAC - Rp, 8.50.129.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.129.3 STATUTORY AUTHORITY: Public Assistance Act, NMSA 1978, Section 27-2-27. The [~~human services department~~] health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.129.3 NMAC - Rp, 8.50.129.3 NMAC, 12/30/2010; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.50.130 NMAC, Sections 1 & 3, effective 7/1/2024.

8.50.130.1 ISSUING AGENCY: [~~New Mexico Human Services Department - Child Support Enforcement Division~~] New Mexico Health Care Authority - Child Support Services Division.
[8.50.130.1 NMAC - Rp, 8.50.130.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.130.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The [~~human services department~~] health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.130.3 NMAC - Rp, 8.50.130.3 NMAC, 12/30/2010; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.50.131 NMAC, Sections 1 & 3, effective 7/1/2024.

8.50.131.1 ISSUING AGENCY: [~~New Mexico Human Services Department - Child Support Enforcement Division~~] New Mexico Health Care Authority - Child Support Services Division.
[8.50.131.1 NMAC - Rp, 8.50.131.1 NMAC, 12/30/2010; A,7/1/2024]

8.50.131.3 STATUTORY AUTHORITY: Public Assistance Act, NMSA 1978, Section 27-2-27. The [~~human services department~~] health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.131.3 NMAC - Rp, 8.50.131.3 NMAC, 12/30/2010; A,7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.50.132 NMAC, Sections 1 & 3, effective 7/1/2024.

8.50.132.1 ISSUING AGENCY: [~~New Mexico Human Services Department - Child Support Enforcement Division~~] New Mexico Health Care Authority - Child Support Services Division.
[8.50.132.1 NMAC - Rp, 8.50.132.1 NMAC, 12/30/2010; A,7/1/2024]

8.50.132.3 STATUTORY AUTHORITY: Public Assistance Act, Paragraph (5) of Subsection A of Section 27-2-27 NMSA 1978. The [~~human services department~~] health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.132.3 NMAC - Rp, 8.50.132.3 NMAC, 12/30/2010; A,7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.100.140 NMAC, Sections 1 & 3, effective 7/1/2024.

8.100.140.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.100.140.1 NMAC - Rp, 8.100.140.1 NMAC, 11/27/2013; A, 7/1/2024]

8.100.140.3 STATUTORY AUTHORITY:

A. Section 27 NMSA 1978 (1992 Repl.) provides for the department to "...adopt, amend and repeal bylaws, rules and regulations..." It also provides for administration of public assistance programs.

B. The income support division (ISD) of the [human services department (HSD)] health care authority (HCA) was created by the [HSD] HCA secretary under authority granted by Paragraph (3) of Subsection B of Section 9-8-6 NMSA 1978.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.100.140.3 NMAC - Rp, 8.100.140.3 NMAC, 11/27/2013 A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.100.640 NMAC, Sections 1 & 3, effective 7/1/2024.

8.100.640.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.100.640.1 NMAC - N, 09/30/2013; A, 7/1/2024]

8.100.640.3 STATUTORY AUTHORITY:

A. Chapter 27 NMSA 1978 (1992 Repl.) provides for the [~~department~~] health care authority (HCA) to "...adopt, amend and repeal bylaws, rules and regulations..." It also provides for administration of public assistance programs.

B. The ISD of the[~~HSD~~] HCA was created by the [~~HSD~~] HCA secretary under authority granted by Paragraph (3) of Subsection B of Section 9-8-6 NMSA 1978.

C. Section 9-8-1 et seq. NMSA 1978 establishes the Health Care Authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.100.640.3 NMAC - N, 09/30/2013 ; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.102.100 NMAC, Sections 1 & 3, effective 7/1/2024.

8.102.100.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.102.100.1 NMAC - Rp, 8.102.100.1 NMAC 11/01/2023; A, 7/1/2024]

8.102.100.3 STATUTORY AUTHORITY:

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

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works (NMW) program was created to replace the AFDC program.

C. Under authority granted to the governor by the federal Social Security Act, the [~~human services department (HSD~~)] health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the department is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the department administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

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

[8.102.100.3 NMAC - Rp, 8.102.100.3 NMAC 11/01/2023; A,7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.102.460 NMAC, Sections 1 & 3, effective 7/1/2024.

8.102.460.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority

[8.102.460.1 NMAC - Rp, 8.102.460.1 NMAC, 04/01/2012; A, 7/1/2024]

8.102.460.3 STATUTORY AUTHORITY:

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

B. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, NMSA 1978, Section 27-2B-1, et seq., the New Mexico works program was created.

C. In coordination with the NMW program, the department administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

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

[8.102.460.3 NMAC - Rp, 8.102.460.3 NMAC, 04/01/2012 ; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.102.461 NMAC, Sections 1 & 3, effective 7/1/2024.

8.102.461.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.

[8.102.461.1 NMAC - N, 04/01/2012; A, 7/1/2024]

8.102.461.3 STATUTORY AUTHORITY:

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

B. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, NMSA 1978, Section 27-2B-1 et seq., the New Mexico works program was created.

C. In coordination with the NMW program, the [~~department~~] health care authority administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

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

[8.102.461.3 NMAC - N, 04/01/2012; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.102.462 NMAC, Sections 1 & 3, effective 7/1/2024.

8.102.462.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.102.462.1 NMAC - N, 04/01/2012; A, 7/1/2024]

8.102.462.3 STATUTORY AUTHORITY:

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

B. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, NMSA 1978, Section 27-2B-1 et seq., the New Mexico works program was created.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.102.462.3 NMAC - N, 04/01/2012; ; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.106.100 NMAC, Sections 1 & 3, effective 7/1/2024.

8.106.100.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.106.100.1 NMAC - Rp, 8.106.100.1 NMAC, 11/01/2023; A,7/1/2024]

8.106.100.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.100.3 NMAC - Rp, 8.106.100.3 NMAC, 11/1/2023; A,7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.106.400 NMAC, Sections 1 & 3, effective 7/1/2024.

8.106.400.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.106.400.1 NMAC - Rp, 8.106.400.1 NMAC, 12/01/2009; A,7/1/2024]

8.106.400.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.400.3 NMAC - Rp, 8.106.400.3 NMAC, 12/01/2009; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.106.410 NMAC, Sections 1 & 3, effective 7/1/2024.

8.106.410.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.106.410.1 NMAC - Rp, 8.106.410.1 NMAC, 12/01/2009; A, 7/1/2024]

8.106.410.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.410.3 NMAC - Rp, 8.106.410.3 NMAC, 12/01/2009; A,7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.106.420 NMAC, Sections 1 & 3, effective 7/1/2024.

8.106.420.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.106.420.1 NMAC - Rp, 8.106.420.1 NMAC, 12/01/2009; A, 7/1/2024]

8.106.420.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the

state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.420.3 NMAC - Rp, 8.106.420.3 NMAC, 12/01/2009; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.106.430 NMAC, Sections 1 & 3, effective 7/1/2024.

8.106.430.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.106.430.1 NMAC - N, 07/01/2004 A, 7/1/2024]

8.106.430.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.430.3 NMAC - N, 07/01/2004; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.106.431 NMAC, Sections 1 & 3, effective 7/1/2024.

Consistent with all other rules converted from the Human Services Department to the Health Care Authority, throughout this rule, if found: "department" is changed to "authority" or "HCA"; "HSD" is changed to "HCA" and that acronym is first introduced in the third section of the rule; "alien" is changed to "non-citizen"; "child support enforcement division" is changed to "child support services division"; "CSED" is changed to "CSSD"; and style and formatting have been updated to conform with current NM State Records Center guidelines.

8.106.431.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.106.431.1 NMAC - N, 12/01/2013; A, 7/1/2024]

8.106.431.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2 along with Chapter 30, Article 52, Section 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare function as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.431.3 NMAC - N, 12/01/2013; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.106.500 NMAC, Sections 1 & 3, effective 7/1/2024.

8.106.500.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.106.500.1 NMAC - N, 07/01/2004; A, 7/1/2024]

8.106.500.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.500.3 NMAC - N, 07/01/2004; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.106.502 NMAC, Sections 1 & 3, effective 7/1/2024.

8.106.502.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.106.502.1 NMAC - N, 12/01/2009; A,7/1/2024]

8.106.502.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.502.3 NMAC - N, 12/01/2009; A,7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.106.510 NMAC, Sections 1 & 3, effective 7/1/2024.

8.106.510.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.106.510.1 NMAC - N, 07/01/2004; A, 7/1/2024]

8.106.510.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.510.3 NMAC - N, 07/01/2004; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.106.520 NMAC, Sections 1 & 3, effective 7/1/2024.

Consistent with all other rules converted from the Human Services Department to the Health Care Authority, throughout this rule, if found: "department" is changed to "authority" or "HCA"; "HSD" is changed to "HCA" and that acronym is first introduced in the third section of the rule; "alien" is changed to "non-citizen"; "child support enforcement division" is changed to "child support services division"; "CSED" is changed to "CSSD"; and style and formatting have been updated to conform with current NM State Records Center guidelines.

8.106.520.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.106.520.1 NMAC - Rp, 8.106.520.1 NMAC 11/01/2023; A, 7/1/2024]

8.106.520.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.520.3 NMAC - Rp, 8.106.520.3 NMAC 11/01/2023; A,7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.106.610 NMAC, Sections 1 & 3, effective 7/1/2024.

8.106.610.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.106.610.1 NMAC - N, 07/01/2004; A, 7/1/2024]

8.106.610.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.610.3 NMAC - N, 07/01/2004; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.106.620 NMAC, Sections 1 & 3, effective 7/1/2024.

8.106.620.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.106.620.1 NMAC - N, 07/01/2004; A, 7/1/2024]

8.106.620.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.620.3 NMAC - N, 07/01/2004; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.106.630 NMAC, Sections 1 & 3, effective 7/1/2024.

8.106.630.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.106.630.1 NMAC - N, 07/01/2004;

A,7/1/2024]

8.106.630.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.630.3 NMAC - N, 07/01/2004; A,7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.106.631 NMAC, Sections 1 & 3, effective 7/1/2024.

Consistent with all other rules converted from the Human Services Department to the Health Care Authority, throughout this rule, if found: "department" is changed to "authority" or "HCA"; "HSD" is changed to "HCA" and that acronym is first introduced in the third section of the rule; "alien" is changed to "non-citizen"; "child support enforcement division" is changed to "child support services division"; "CSED" is changed to "CSSD"; and style and formatting have been updated to conform with current NM State Records Center guidelines.

8.106.631.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.106.631.1 NMAC - N, 11/1/2020; A,7/1/2024]

8.106.631.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.631.3 NMAC - N, 11/1/2020 ; A,7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.119.100 NMAC, Sections 1 & 3, effective 7/1/2024.

8.119.100.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.119.100.1 NMAC - N, 11/01/2013; A, 7/1/2024]

8.119.100.3 STATUTORY AUTHORITY:

A. The Refugee Resettlement Program (RRP) is authorized under Title IV of the Immigration and Nationality Act of 1980. The act designates the federal department of health and human services (DHHS) as the federal administering agency. RRP regulations are issued by DHHS in the code of federal regulations, Title 45, Part 400, which is supplemented by administrative and program instructions issued by the federal department from time to time.

B. In accordance with authority granted to the department by NMSA 1978, section 27-1-3(J), and pursuant to Executive Order No. 80-62, dated 10/01/81, the governor of the state of New Mexico has designated the [~~human services department (HSD)~~] health care authority (HCA) as the single state agency responsible for administering the program in New Mexico.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.119.100.3 NMAC - N, 11/01/2013; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.139.410 NMAC, Sections 1 & 3, effective 7/1/2024.

8.139.410.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.139.410.1 NMAC - Rp, 8.139.410.1 NMAC, 11/1/2023; A, 7/1/2024]

8.139.410.3 STATUTORY AUTHORITY: The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Administration of the [~~human services department (HSD)~~] health care authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.139.410.3 NMAC - Rp, 8.139.410.3 NMAC, 11/1/2023; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.139.501 NMAC, Sections 1 & 3, effective 7/1/2024.

8.139.501.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.139.501.1 NMAC - N, 09/01/2003; A, 7/1/2024]

8.139.501.3 STATUTORY AUTHORITY: The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA 1978. Administration of the [~~human services department (HSD)~~] health care authority (HCA) including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.139.501.3 NMAC - N, 09/01/2003; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.139.502 NMAC, Sections 1 & 3, effective 7/1/2024.

8.139.502.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.139.502.1 NMAC - N, 8/30/2007; A, 7/1/2024]

8.139.502.3 STATUTORY AUTHORITY: The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA 1978. Administration of the [~~human services department (HSD)~~] health care authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.139.502.3 NMAC - N, 8/30/2007; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.139.503 NMAC, Sections 1 & 3, effective 7/1/2024.

8.139.503.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.139.503.1 NMAC - N, 06/01/2009; A, 7/1/2024]

8.139.503.3 STATUTORY AUTHORITY: The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Administration of the [~~human services department (HSD)~~] health care authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.139.503.3 NMAC - N, 06/01/2009; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.139.504 NMAC, Sections 1 & 3, effective 7/1/2024.

8.139.504.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority (HCA).
[8.139.504.1 NMAC - N, 08/01/2011; A, 7/1/2024]

8.139.504.3 STATUTORY AUTHORITY: The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Administration of the [~~human services department (HSD~~)] health care authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.139.504.3 NMAC - N, 08/01/2011; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.139.520 NMAC, Sections 1 & 3, effective 7/1/2024.

8.139.520.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.139.520.1 NMAC - Rp, 8.139.520.1 NMAC, 11/21/2023; A, 7/1/2024]

8.139.520.3 STATUTORY AUTHORITY: The food stamp

program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270/282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Administration of the [~~human services department (HSD)~~] health care authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.139.520.3 NMAC - Rp, 8.139.520.3 NMAC, 11/21/2023 A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.139.527 NMAC, Sections 1 & 3, effective 7/1/2024.

8.139.527.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.139.527.1 NMAC - Rp, 8.139.527.1 NMAC 11/01/2023; A, 7/1/2024]

8.139.527.3 STATUTORY AUTHORITY: The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270/282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Administration of the [~~human services department (HSD)~~] health care authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.139.527.3 NMAC - Rp, 8.139.527.3 NMAC 11/01/2023; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.200.410 NMAC, Sections 1 & 3, effective 7/1/2024.

8.200.410.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.200.410.1 NMAC - Rp, 8.200.410.1 NMAC, 10/1/2017; A, 7/1/2024]

8.200.410.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.200.410.3 NMAC - Rp, 8.200.410.3 NMAC, 10/1/2017; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.200.420 NMAC, Sections 1 & 3, effective 7/1/2024.

8.200.420.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD~~)] New Mexico Health Care Authority.
[8.200.420.1 NMAC - Rp, 8.200.420.1 NMAC, 1/1/2014 ; A,7/1/2024]

8.200.420.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.200.420.3 NMAC - Rp, 8.200.420.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.201.400 NMAC, Sections 1 & 3, effective 7/1/2024.

8.201.400.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.201.400.1 NMAC - Rp, 8.201.400.1 NMAC, 1/1/2019; A, 7/1/2024]

8.201.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [~~human services department~~] health care authority pursuant to state statute. See Sections 27-2-12 *et seq*., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care

purchasing and regulation.
[8.201.400.3 NMAC - Rp, 8.201.400.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.201.600 NMAC, Sections 1 & 3, effective 7/1/2024.

8.201.600.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.201.600.1 NMAC - Rp, 8.201.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.201.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [~~human services department~~] health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.201.600.3 NMAC - Rp, 8.201.600.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.206.400 NMAC, Sections 1 & 3, effective 7/1/2024.

Consistent with all other rules converted from the Human Services Department to the Health Care Authority, throughout this rule, if found: "department" is changed to "authority" or "HCA"; "HSD" is changed to "HCA" and that acronym is first introduced in the third section of the rule; "alien" is changed to "non-citizen"; "child support enforcement division" is changed to "child support services division"; "CSED" is changed to "CSSD"; and style and formatting have been updated to conform with current NM State Records Center guidelines.

8.206.400.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.206.400.1 NMAC - Rp, 8.206.400.1 NMAC, 10/1/2015; A, 7/1/2024]

8.206.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.206.400.3 NMAC - Rp, 8.206.400.3 NMAC, 10/1/2015; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.215.400 NMAC, Sections 1 & 3, effective 7/1/2024.

8.215.400.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.215.400.1 NMAC - Rp, 8.215.400.1 NMAC, 1/1/2019; A, 7/1/2024]

8.215.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [~~human services department~~] health care authority pursuant to state statute. See Section 27-2-12 *et seq*., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.215.400.3 NMAC - Rp, 8.215.400.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.215.500 NMAC, Sections 1 & 3, effective 7/1/2024.

8.215.500.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority (HCA).
[8.215.500.1 NMAC - Rp, 8.215.500.1 NMAC, 3/1/2018; A,7/1/2024]

8.215.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [~~human services department~~] health care authority pursuant to state statute. See Section 27-2-12 et. seq., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.215.500.3 NMAC - Rp,

8.215.500.3 NMAC, 3/1/2018; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.215.600 NMAC, Sections 1 & 3, effective 7/1/2024.

8.215.600.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.215.600.1 NMAC - Rp, 8.215.600.1 NMAC, 1/1/2019; A,7/1/2024]

8.215.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [~~human services department~~] health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.215.600.3 NMAC - Rp, 8.215.600.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.231.400 NMAC, Sections 1 & 3, effective 7/1/2024.

8.231.400.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.231.400.1 NMAC - Rp, 8.231.400.1 NMAC, 10/1/2017; A,7/1/2024]

8.231.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [~~human services department~~] health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.231.400.3 NMAC - Rp, 8.231.400.3 NMAC, 10/1/2017; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.231.500 NMAC, Sections 1 & 3, effective 7/1/2024.

8.231.500.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.231.500.1 NMAC - Rp, 8.231.500.1 NMAC, 10/1/2017; A, 7/1/2024]

8.231.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.231.500.3 NMAC - Rp, 8.231.500.3 NMAC, 10/1/2017; A,7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.231.600 NMAC, Sections 1 & 3, effective 7/1/2024.

8.231.600.1 ISSUING AGENCY: New Mexico [~~Human Services Department (HSD)~~] Health Care Authority.
[8.231.600.1 NMAC - Rp, 8.231.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.231.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.231.600.3 NMAC - Rp, 8.231.600.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.234.400 NMAC, Sections 1 & 3, effective 7/1/2024.

8.234.400.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD~~)] New Mexico Health Care Authority.
[8.234.400.1 NMAC - Rp, 8.234.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.234.400.3 STATUTORY AUTHORITY: The New Mexico

medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See, NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.234.400.3 NMAC - Rp, 8.234.400.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.234.500 NMAC, Sections 1 & 3, effective 7/1/2024.

8.234.500.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.234.500.1 NMAC - Rp, 8.234.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.234.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.234.500.3 NMAC - Rp, 8.234.500.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.234.600 NMAC, Sections 1 & 3, effective 7/1/2024.

8.234.600.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.234.600.1 NMAC - Rp, 8.234.600.1 NMAC, 1/1/2014; A, 7/1/2024]

8.234.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.234.600.3 NMAC - Rp, 8.234.600.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.242.400 NMAC, Sections 1 & 3, effective 7/1/2024.

8.242.400.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.242.400.1 NMAC - Rp, 8.242.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.242.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See, Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.242.400.3 NMAC - Rp, 8.242.400.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.242.500 NMAC, Sections 1 & 3, effective 7/1/2024.

8.242.500.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.242.500.1 NMAC - Rp, 8.242.500.1 NMAC, 1/1/2014; A,7 /1/2024]

8.242.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.242.500.3 NMAC - Rp, 8.242.500.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.242.600 NMAC, Sections 1 & 3, effective

7/1/2024.

8.242.600.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.242.600.1 NMAC - Rp, 8.242.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.242.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.242.600.3 NMAC - Rp, 8.242.600.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.243.400 NMAC, Sections 1 & 3, effective 7/1/2024.

8.243.400.1 ISSUING AGENCY: [~~Human Services Department~~] New Mexico Health Care Authority.
[8.243.400.1 NMAC - Rp, 8.243.400.1 NMAC, 1/1/2019; A, 7/1/2024]

8.243.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended by the state human services department pursuant to state statute. See 27-2-12 et. seq., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.243.400.3 NMAC - Rp, 8.243.400.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.243.500 NMAC, Sections 1 & 3, effective 7/1/2024.

8.243.500.1 ISSUING AGENCY: [~~Human Services Department~~] New Mexico Health Care Authority (HCA).
[8.243.500.1 NMAC - N, 1/1/2001; A, 7/1/2024]

8.243.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended by the state [human services department] health care authority pursuant to state statute. See Section 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.243.500.3 NMAC - N, 1/1/2001; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.243.600 NMAC, Sections 1 & 3, effective 7/1/2024.

8.243.600.1 ISSUING AGENCY: [~~Human Services Department (HSD)~~] New Mexico Health Care Authority(HCA).
[8.243.600.1 NMAC - Rp, 8.243.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.243.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 *et seq*., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.243.600.3 NMAC - Rp, 8.243.600.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.245.600 NMAC, Sections 1 & 3, effective 7/1/2024.

8.245.600.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.245.600.1 NMAC - Rp, 8.245.600.1 NMAC, 1/1/2019; A, 7/1/2024]]

8.245.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [~~human services department~~] health care authority (HCA) pursuant to state statute. See, Section 27-2-12 *et seq*., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating

to health care facility licensure and health care purchasing and regulation.
[8.245.600.3 NMAC - Rp, 8.245.600.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.249.400 NMAC, Sections 1 & 3, effective 7/1/2024.

8.249.400.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority (HCA).
[8.249.400.1 NMAC - Rp, 8.249.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.249.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.249.400.3 NMAC - Rp, 8.249.400.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.249.500 NMAC, Sections 1 & 3, effective 7/1/2024.

8.249.500.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority (HCA).
[8.249.500.1 NMAC - Rp, 8.249.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.249.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.249.500.3 NMAC - Rp, 8.249.500.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.249.600 NMAC, Sections 1 & 3, effective 7/1/2024.

8.249.600.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD~~] New Mexico Health Care Authority (HCA).
[8.249.600.1 NMAC - Rp, 8.249.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.249.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 *et seq*., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.249.600.3 NMAC - Rp, 8.249.600.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.250.400 NMAC, Sections 1 & 3, effective 7/1/2024.

8.250.400.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.250.400.1 NMAC - Rp, 8.250.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.250.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.250.400.3 NMAC - Rp, 8.250.400.3 NMAC, 1/1/2014 ; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.250.500 NMAC, Sections 1 & 3, effective 7/1/2024.

8.250.500.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.250.500.1 NMAC - Rp, 8.250.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.250.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.250.500.3 NMAC - Rp, 8.250.500.3 NMAC, 1/1/2014 ; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.250.600 NMAC, Sections 1 & 3, effective 7/1/2024.

8.250.600.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.250.600.1 NMAC - Rp, 8.250.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.250.600.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978, (Chapter 27, Articles 1 and 2) authorizes the state to administer the medicaid program. Section 4732 of the 1997 Balanced Budget Act creates a separate group of eligible individuals, to be known as qualified individuals 1 (QI1s), with income between one hundred twenty percent and one hundred thirty-five percent of the federal poverty level. The benefit is limited to the payment of the monthly medicare part B insurance premium. Funding is available under one hundred percent federal block grant money. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.250.600.3 NMAC - Rp, 8.250.600.3 NMAC, 1/1/2019 ; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.252.500 NMAC, Sections 1 & 3, effective 7/1/2024.

8.252.500.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.252.500.1 NMAC - Rp, 8.252.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.252.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.252.500.3 NMAC - Rp, 8.252.500.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.252.600 NMAC, Sections 1 & 3, effective 7/1/2024.

8.252.600.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.252.600.1 NMAC - Rp, 8.252.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.252.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 *et seq*., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.252.600.3 NMAC - Rp, 8.252.600.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.259.400 NMAC, Sections 1 & 3, effective 7/1/2024.

8.259.400.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.259.400.1 NMAC - Rp, 8.259.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.259.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See, Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.259.400.3 NMAC - Rp, 8.259.400.3 NMAC, 1/1/2014 ; A,

7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.259.500 NMAC, Sections 1 & 3, effective 7/1/2024.

8.259.500.1 ISSUING AGENCY: [New Mexico Human Services Department (HSD)] New Mexico Health Care Authority.
[8.259.500.1 NMAC - Rp, 8.259.500.1 NMAC, 1/1/2014; A,7/1/2024; A, 7/1/2024]

8.259.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.259.500.3 NMAC - Rp, 8.259.500.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.259.600 NMAC, Sections 1 & 3, effective 7/1/2024.

8.259.600.1 ISSUING AGENCY: [New Mexico Human Services Department (HSD)] New Mexico Health Care Authority.
[8.259.600.1 NMAC - Rp, 8.259.600.1 NMAC, 1/1/2014; A, 7/1/2024]

8.259.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.259.600.3 NMAC - Rp, 8.259.600.3 NMAC, 1/1/2014 ; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.280.400 NMAC, Sections 1 & 3, effective 7/1/2024.

8.280.400.1 ISSUING AGENCY: [New Mexico Human Services Department] New Mexico Health Care Authority.
[8.280.400.1 NMAC - Rp, 8.280.400.1 NMAC, 1/1/2019; A,7/1/2024; A, 7/1/2024]

8.280.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [human services department] health care authority pursuant to state statute. See Section 27-2-12 *et seq*., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.280.400.3 NMAC - Rp, 8.280.400.3 NMAC, 1/1/2019; A,7/1/2024; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.280.600 NMAC, Sections 1 & 3, effective 7/1/2024.

8.280.600.1 ISSUING AGENCY: [New Mexico Human Services Department] New Mexico Health Care Authority.
[8.280.600.1 NMAC - Rp, 8.280.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.280.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [human services department] health care authority pursuant to state statute. See Section 27-2-12 *et seq*., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.280.600.3 NMAC - Rp, 8.280.600.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.281.400 NMAC, Sections 1 & 3, effective 7/1/2024.

8.281.400.1 ISSUING AGENCY: [New Mexico Human Services Department (HSD)] New Mexico Health Care Authority.
[8.281.400.1 NMAC - Rp, 8.281.400.1 NMAC, 1/1/2019; A, 5/1/2021; A, 7/1/2024]

8.281.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered

pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [~~human services department~~] health care authority pursuant to state statute. See, Section 27-2-12 *et seq*., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.281.400.3 NMAC - Rp, 8.281.400.3 NMAC, 1/1/2019 ; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.281.500 NMAC, Sections 1 & 3, effective 7/1/2024.

8.281.500.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.

[8.281.500.1 NMAC - Rp, 8.281.500.1 NMAC, 8/15/2015; A, 7/1/2024]

8.281.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See, Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.281.500.3 NMAC - Rp, 8.281.500.3 NMAC, 8/15/2015 ; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.281.510 NMAC, Sections 1 & 3, effective 7/1/2024.

8.281.510.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.281.510.1 NMAC - N, 10/1/2012; A,7/1/2024]

8.281.510.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the [~~state human services department~~] health care authority pursuant to state statute. See Sections 27-2-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.281.510.3 NMAC - N, 10/1/2012; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.281.600 NMAC, Sections 1 & 3, effective 7/1/2024.

8.281.600.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.281.600.1 NMAC - Rp, 8.281.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.281.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [~~human services department~~] health care authority pursuant to state statute. See Section 27-2-12 *et seq*., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.281.600.3 NMAC - Rp, 8.281.600.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.285.400 NMAC, Sections 1 & 3, effective 7/1/2024.

Consistent with all other rules converted from the Human Services Department to the Health Care Authority, throughout this rule, if found: "department" is changed to "authority" or "HCA"; "HSD" is changed to "HCA" and that acronym is first introduced in the third section of the rule; "alien" is changed to "non-citizen"; "child support enforcement division" is changed to "child support services division"; "CSED" is changed to "CSSD"; and style and formatting have been updated to conform with current NM State Records Center guidelines.

8.285.400.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.285.400.1 NMAC - Rp, 8.285.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.285.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended

or by state statute. See NMSA 1978, Section 27-1-12. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.285.400.3 NMAC - Rp, 8.285.400.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.290.400 NMAC, Sections 1 & 3, effective 7/1/2024.

8.290.400.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.290.400.1 NMAC - Rp, 8.290.400.1 NMAC, 1/1/2019; A, 7/1/2024]

8.290.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [~~human services department~~] health care authority pursuant to state statute. See Section 27-2-12 *et seq*., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.290.400.3 NMAC - Rp, 8.290.400.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.290.600 NMAC, Sections 1 & 3, effective 7/1/2024.

8.290.600.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.290.600.1 NMAC - Rp, 8.290.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.290.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [~~human services department~~] health care authority (HCA) pursuant to state statute. See Section 27-2-12 *et seq.*, NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.290.600.3 NMAC - Rp, 8.290.600.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.291.400 NMAC, Sections 1 & 3, effective 7/1/2024.

8.291.400.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.291.400.1 NMAC - Rp, 8.291.400.1 NMAC, 10/1/2017; A, 7/1/2024]

8.291.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.291.400.3 NMAC - Rp, 8.291.400.3 NMAC, 10/1/2017; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.291.410 Sections 1 & 3, effective 7/1/2024.

8.291.410.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority (HCA).
[8.291.410.1 NMAC - Rp, 8.291.410.1 NMAC, 10/1/2017; A, 7/1/2024]

8.291.410.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.291.410.3 NMAC - Rp, 8.291.410.3 NMAC, 10/1/2017; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.291.420 NMAC, Sections 1 & 3, effective 7/1/2024.

8.291.420.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.291.420.1 NMAC - Rp, 8.291.420.1 NMAC, 1/1/2014; A,

7/1/2024]

8.291.420.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.291.420.3 NMAC - Rp, 8.291.420.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.292.400 NMAC, Sections 1 & 3, effective 7/1/2024.

8.292.400.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.292.400.1 NMAC - Rp, 8.292.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.292.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.292.400.3 NMAC - Rp, 8.292.400.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.292.500 NMAC, Sections 1 & 3, effective 7/1/2024.

8.292.500.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.292.500.1 NMAC - Rp, 8.292.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.292.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See, Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.292.500.3 NMAC - Rp, 8.292.500.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.292.600 NMAC, Sections 1 & 3, effective 7/1/2024.

8.292.600.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.292.600.1 NMAC - Rp, 8.292.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.292.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 *et seq*., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.292.600.3 NMAC - Rp, 8.292.600.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.293.400 NMAC, Sections 1 & 3, effective 7/1/2024.

8.293.400.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD~~] New Mexico Health Care Authority.
[8.293.400.1 NMAC - Rp, 8.293.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.293.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See, Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.293.400.3 NMAC - Rp, 8.293.400.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.293.500 NMAC, Sections 1 & 3, effective 7/1/2024.

8.293.500.1 ISSUING

AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.293.500.1 NMAC - Rp, 8.293.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.293.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.293.500.3 NMAC - Rp, 8.293.500.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.293.600 NMAC, Sections 1 & 3, effective 7/1/2024.

8.293.600.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.293.600.1 NMAC - Rp, 8.293.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.293.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 *et seq*., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.293.600.3 NMAC - Rp, 8.293.600.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.294.400 NMAC, Sections 1 & 3, effective 7/1/2024.

8.294.400.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.294.400.1 NMAC - Rp, 8.294.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.294.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See, Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.294.400.3 NMAC - Rp, 8.294.400.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.294.500 NMAC, Sections 1 & 3, effective 7/1/2024.

8.294.500.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.294.500.1 NMAC - Rp, 8.294.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.294.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See, Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.294.500.3 NMAC - Rp, 8.294.500.3 NMAC, 1/1/2014 ; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.294.600 NMAC, Sections 1 & 3, effective 7/1/2024.

8.294.600.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.294.600.1 NMAC - Rp, 8.294.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.294.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 *et seq*., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.294.600.3 NMAC - Rp, 8.294.600.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.295.400 NMAC, Sections 1 & 3, effective 7/1/2024.

8.295.400.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority. [8.295.400.1 NMAC - Rp, 8.295.400.1 NMAC, 1/1/2014; A,7/1/2024]

8.295.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX and XXI of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. [8.295.400.3 NMAC - Rp, 8.295.400.3 NMAC, 1/1/2014; A,7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.295.600 NMAC, Sections 1 & 3, effective 7/1/2024.

8.295.600.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority. [8.295.600.1 NMAC - Rp, 8.295.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.295.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX and XXI of the Social Security Act as amended or by state statute. See Section 27-1-12 *et seq*., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. [8.295.600.3 NMAC - Rp, 8.295.600.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.295.600 NMAC, Sections 1 & 3, effective 7/1/2024.

8.295.600.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority. [8.295.600.1 NMAC - Rp, 8.295.600.1 NMAC, 1/1/2019; A,7/1/2024]

8.295.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX and XXI of the Social Security Act as amended or by state statute. See Section 27-1-12 *et seq*., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. [8.295.600.3 NMAC - Rp, 8.295.600.3 NMAC, 1/1/2019; A,7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.296.400 NMAC, Sections 1 & 3, effective 7/1/2024.

8.296.400.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority. [8.296.400.1 NMAC - Rp, 8.296.400.1 NMAC, 1/1/2019; A, 7/1/2024]

8.296.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 *et seq*., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. [8.296.400.3 NMAC - Rp, 8.296.400.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.296.500 NMAC, Sections 1 & 3, effective 7/1/2024.

8.296.500.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority. [8.296.500.1 NMAC - Rp, 8.296.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.296.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. [8.296.500.3 NMAC - Rp, 8.296.500.3 NMAC, 1/1/2014; A,

7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.296.600 NMAC, Sections 1 & 3, effective 7/1/2024.

8.296.600.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority. [8.296.600.1 NMAC - Rp, 8.296.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.296.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 *et seq*., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. [8.296.600.3 NMAC - Rp, 8.296.600.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.297.400 NMAC, Sections 1 & 3, effective 7/1/2024.

8.297.400.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority. [8.297.400.1 NMAC - Rp, 8.297.400.1 NMAC, 1/1/2019; A, 7/1/2024]

8.297.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. [8.297.400.3 NMAC - Rp, 8.297.400.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.297.500 NMAC, Sections 1 & 3, effective 7/1/2024.

8.297.500.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority. [8.297.500.1 NMAC - Rp, 8.297.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.297.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. [8.297.500.3 NMAC - Rp, 8.297.500.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.297.600 NMAC, Sections 1 & 3, effective 7/1/2024.

8.297.600.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority. [8.297.600.1 NMAC - Rp, 8.297.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.297.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 *et seq*., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. [8.297.600.3 NMAC - Rp, 8.297.600.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.298.400 NMAC, Sections 1 & 3, effective 7/1/2024.

8.298.400.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority. [8.298.400.1 NMAC - Rp, 8.298.400.1 NMAC, 1/1/2019; A, 7/1/2024]

8.298.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 *et seq*., NMSA 1978. Section 9-8-1 et seq. NMSA

1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.298.400.3 NMAC - Rp, 8.298.400.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.298.500 NMAC, Sections 1 & 3, effective 7/1/2024.

8.298.500.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.298.500.1 NMAC - Rp, 8.298.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.298.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.298.500.3 NMAC - Rp, 8.298.500.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.298.600 NMAC, Sections 1 & 3, effective 7/1/2024.

8.298.600.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.298.600.1 NMAC - Rp, 8.298.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.298.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 *et seq*., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.298.600.3 NMAC - Rp, 8.298.600.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.299.400 NMAC, Sections 1 & 3, effective 7/1/2024.

8.299.400.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.299.400.1 NMAC - Rp, 8.299.400.1 NMAC, 1/1/2019; A, 7/1/2024]

8.299.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 *et seq*., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.299.400.3 NMAC - Rp, 8.299.400.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.299.500 NMAC, Sections 1 & 3, effective 7/1/2024.

8.299.500.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.299.500.1 NMAC - N, 10/1/2017; A, 7/1/2024]

8.299.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq, NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.299.500.3 NMAC - N, 10/1/2017; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.299.600 NMAC, Sections 1 & 3, effective 7/1/2024.

8.299.600.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.299.600.1 NMAC – Rp, 8.299.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.299.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated

by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 *et seq*., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.299.600.3 NMAC - Rp, 8.299.600.3 NMAC, 1/1/2019; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.300.22 NMAC, Sections 1 & 3, effective 7/1/2024.

8.300.22.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.300.22.1 NMAC - N, 8/1/2011; A, 7/1/2024]

8.300.22.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27/1/2012 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.300.22.3 NMAC - N, 8/1/2011; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.302.2 NMAC, Sections 1 & 3, effective 7/1/2024.

8.302.2.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.302.2.1 NMAC - Rp, 8.302.2.1 NMAC, 10/1/2017; A, 7/1/2024]

8.302.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services (HHS) under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 *et seq*., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.302.2.3 NMAC - Rp, 8.302.2.3 NMAC, 10/1/2017; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.302.3 NMAC, Sections 1 & 3, effective 7/1/2024.

8.302.3.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.302.3.1 NMAC - Rp, 8.302.3.1 NMAC, 5/1/2018; A, 7/1/2024]

8.302.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by state statute. See Section 27-2-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.302.3.3 NMAC - Rp, 8.302.3.3 NMAC, 5/1/2018; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.308.2 NMAC, Sections 1 & 3, effective 7/1/2024.

8.308.2.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.308.2.1 NMAC - Rp, 8.308.2.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.2.3 NMAC - Rp, 8.308.2.3 NMAC, 5/1/2018; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.308.6 NMAC, Sections 1 & 3, effective 7/1/2024.

8.308.6.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.308.6.1 NMAC - Rp, 8.308.6.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.6.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health

care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.6.3 NMAC - Rp, 8.308.6.3 NMAC, 5/1/2018; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.308.7 NMAC, Sections 1 & 3, effective 7/1/2024.

8.308.7.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.308.7.1 NMAC - Rp, 8.308.7.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.7.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.7.3 NMAC - Rp, 8.308.7.3 NMAC, 5/1/2018; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.308.8 NMAC, Sections 1 & 3, effective 7/1/2024.

8.308.8.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.308.8.1 NMAC - Rp, 8.308.8.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.8.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.8.3 NMAC - Rp, 8.308.8.3 NMAC, 5/1/2018; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.308.9 NMAC, Sections 1 & 3, effective 7/1/2024.

8.308.9.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.308.9.1 NMAC - Rp, 8.308.9.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.9.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.9.3 NMAC - Rp, 8.308.9.3 NMAC, 5/1/2018; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.308.10 NMAC, Sections 1 & 3, effective 7/1/2024.

8.308.10.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD~~)] New Mexico Health Care Authority.
[8.308.10.1 NMAC - Rp, 8.308.10.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.10.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.10.3 NMAC - Rp, 8.308.10.3 NMAC, 5/1/2018; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.308.11 NMAC, Sections 1 & 3, effective 7/1/2024.

8.308.11.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.308.11.1 NMAC - Rp, 8.308.11.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.11.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.11.3 NMAC - Rp, 8.308.11.3 NMAC, 5/1/2018; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.308.12 NMAC, Sections 1 & 3, effective 7/1/2024.

8.308.12.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.308.12.1 NMAC - Rp, 8.308.12.1 NMAC, 3/1/2017; A, 7/1/2024]

8.308.12.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 *et seq*., NMSA1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.12.3 NMAC - Rp, 8.308.12.3 NMAC, 3/1/2017; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.308.13 NMAC, Sections 1 & 3, effective 7/1/2024.

8.308.13.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.308.13.1 NMAC - N, 1/1/2014; A, 7/1/2024]

8.308.13.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.13.3 NMAC - N, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.308.14 NMAC, Sections 1 & 3, effective 7/1/2024.

8.308.14.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.308.14.1 NMAC - Rp, 8.308.14.1 NMAC, 10/1/2017; A, 7/1/2024]

8.308.14.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.14.3 NMAC - Rp, 8.308.14.3 NMAC, 10/1/2017; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.308.15 NMAC, Sections 1 & 3, effective 7/1/2024.

8.308.15.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.308.15.1 NMAC - Rp, 8.308.15.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.15.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Sections 27-2-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.15.3 NMAC - Rp, 8.308.15.3 NMAC, 5/1/2018; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.308.20 NMAC, Sections 1 & 3, effective 7/1/2024.

8.308.20.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.308.20.1 NMAC - N, 1/1/2014; A, 7/1/2024]

8.308.20.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.20.3 NMAC - N, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.308.21 NMAC, Sections 1 & 3, effective 7/1/2024.

8.308.21.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.308.21.1 NMAC - Rp, 8.308.21.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.21.3 STATUTORY AUTHORITY: The New Mexico Medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.21.3 NMAC - Rp, 8.308.21.3 NMAC, 5/1/2018; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.308.22 NMAC, Sections 1 & 3, effective 7/1/2024.

8.308.22.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.308.22.1 NMAC - N, 1/1/2014; A, 7/1/2024]

8.308.22.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.22.3 NMAC - N, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.309.4 NMAC, Sections 1 & 3, effective 7/1/2024.

8.309.4.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.309.4.1 NMAC - N, 1/1/2014; A, 7/1/2024]

8.309.4.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.309.4.3 NMAC - N, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.310.2 NMAC, Sections 1 & 3, effective 7/1/2024.

8.310.2.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.310.2.1 NMAC - Rp, 8.310.2.1 NMAC, 1/1/2014; A, 7/1/2024]

8.310.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Sections 27-2-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.310.2.3 NMAC - Rp, 8.310.2.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.310.3 NMAC, Sections 1 & 3, effective 7/1/2024.

8.310.3.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.310.3.1 NMAC - Rp, 8.310.3.1 NMAC, 1/1/2023; A, 7/1/2024]

8.310.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.310.3.3 NMAC - Rp, 8.310.3.3 NMAC, 1/1/2023; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.310.9 NMAC, Sections 1 & 3, effective 7/1/2024.

8.310.9.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.310.9.1 NMAC - Rp, 8.310.3.1 NMAC, 1/1/2014; A, 7/1/2024]

8.310.9.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [human services department] health care authority pursuant to state statute. See Sections 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.310.9.3 NMAC - Rp, 8.310.3.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.310.12 NMAC, Sections 1 & 3, effective 7/1/2024.

8.310.12.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.310.12.1 NMAC - N, 11/1/2014; A, 7/1/2024]

8.310.12.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.310.12.3 NMAC - N, 11/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.311.3 NMAC, Sections 1 & 3, effective 7/1/2024.

8.311.3.1 ISSUING AGENCY: [~~Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.311.3.1 NMAC - Rp, 8.311.3.1 NMAC, 6/1/2016; A, 7/1/2024]

8.311.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under the Social Security Act as amended or by state statute. See Section 27-2-12 *et seq* NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.311.3.3 NMAC - Rp, 8.311.3.3 NMAC, 6/1/2016; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.311.5 NMAC, Sections 1 & 3, effective 7/1/2024.

8.311.5.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[2/1/1995; 8.311.5.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.311.5.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [human services department] health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[2/1/1995; 8.311.5.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.312.2 NMAC, Sections 1 & 3, effective 7/1/2024.

8.312.2.1 ISSUING

AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.312.2.1 NMAC - Rp, 8.312.2.1 NMAC, 8/1/2014; A, 7/1/2024]

8.312.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.312.2.3 NMAC - Rp, 8.312.2.3 NMAC, 8/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.312.3 NMAC, Sections 1 & 3, effective 7/1/2024.

8.312.3.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[8.312.3.1 NMAC - Rp, 8.312.3.1 NMAC, 9/1/2021; A, 7/1/2024]

8.312.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [~~human services department~~] health care authority pursuant to state statute. See Section 27-2-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.312.3.3 NMAC - Rp, 8.312.3.3 NMAC, 9/1/2021; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.314.3 NMAC, Sections 1 & 3, effective 7/1/2024.

8.314.3.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.314.3.1 NMAC - Rp, 8 .314.3.1 NMAC, 3/1/2018; A, 7/1/2024]

8.314.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [~~human services department~~] health care authority pursuant to state statute. See Section 27-2-12, NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.314.3.3 NMAC - Rp, 8 .314.3.3 NMAC, 3/1/2018; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.314.5 NMAC, Sections 1 & 3, effective 7/1/2024.

8.314.5.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.314.5.1 NMAC - Rp, 8.314.5.1 NMAC, 12/1/2018; A, 7/1/2024]

8.314.5.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [~~human services department~~] health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.314.5.3 NMAC - Rp, 8.314.5.3 NMAC, 12/1/2018; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.314.6 NMAC, Sections 1 & 3, effective 7/1/2024.

8.314.6.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD~~)] New Mexico Health Care Authority.
[8.314.6.1 NMAC - Rp, 8.314.6.1 NMAC, 3/1/2016; A, 7/1/2024]

8.314.6.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Titles XI, XIX, and XXI of the Social Security Act as amended or by state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.314.6.3 NMAC - Rp, 8.314.6.3 NMAC, 3/1/2016; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.314.7

NMAC, Sections 1 & 3, effective 7/1/2024.

8.314.7.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority. [8.314.7.1 NMAC - N, 4/1/2021; A, 7/1/2024]

8.314.7.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Titles XI, XIX, and XXI of the Social Security Act as amended or by state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. [8.314.7.3 NMAC - N, 4/1/2021; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.320.2 NMAC, Sections 1 & 3, effective 7/1/2024.

8.320.2.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority. [8.320.2.1 NMAC - Rp, 8.320.2.1 NMAC, 1/1/2014; A, 7/1/2024]

8.320.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. [8.320.2.3 NMAC - Rp, 8.320.2.3 NMAC, 1/1/201; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.320.6 NMAC, Sections 1 & 3, effective 7/1/2024.

8.320.6.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority. [8.320.6.1 NMAC - Rp, 8.320.6.1 NMAC, 7/1/2015; A, 7/1/2024]

8.320.6.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. [8.320.6.3 NMAC - Rp, 8.320.6.3 NMAC, 7/1/2015; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.324.4 NMAC, Sections 1 & 3, effective 7/1/2024.

8.324.4.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority. [8.324.4.1 NMAC - Rp, 8.324.4.1 NMAC, 1/1/2014; A, 7/1/2024]

8.324.4.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-2-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. [8.324.4.3 NMAC - Rp, 8.324.4.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.324.5 NMAC, Sections 1 & 3, effective 7/1/2024.

8.324.5.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority. [8.324.5.1 NMAC - Rp, 8.324.5.1 NMAC, 1/1/2014; A, 7/1/2024]

8.324.5.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. [8.324.5.3 NMAC - Rp, 8.324.5.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.324.7 NMAC, Sections 1 & 3, effective 7/1/2024.

8.324.7.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.324.7.1 NMAC - Rp, 8.324.7.1 NMAC, 1/1/2014; A, 7/1/2024]

8.324.7.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.324.7.3 NMAC – Rp, 8.324.7.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.325.8 NMAC, Sections 1 & 3, effective 7/1/2024.

8.325.8.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[2/1/1995; 8.325.8.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.325.8.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [human services department] health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[2/1/1995; 8.325.8.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.326.3 NMAC, Sections 1 & 3, effective 7/1/2024.

8.326.3.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[2/1/1995; 8.326.3.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.326.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [~~human services department~~] health care authority pursuant to state statute. See Sections 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[2/1/1995; 8.326.3.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.326.4, Sections 1 & 3, effective 7/1/2024.

8.326.4.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[2/1/1995; 8.326.4.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.326.4.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [human services department] pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[2/1/1995; 8.326.4.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.326.5 NMAC, Sections 1 & 3, effective 7/1/2024.

8.326.5.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[2/1/1995; 8.326.5.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.326.5.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [human services department] health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section

9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[2/1/1995; 8.326.5.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.326.6 NMAC, Sections 1 & 3, effective 7/1/2024.

8.326.6.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[2/1/1995; 8.326.6.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.326.6.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [human services department] health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[2/1/1995; 8.326.6.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.326.7 NMAC, Sections 1 & 3, effective 7/1/2024.

8.326.7.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[2/1/1995; 8.326.7.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.326.7.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [human services department] health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[2/1/1995; 8.326.7.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.326.8 NMAC, Sections 1 & 3, effective 7/1/2024.

8.326.8.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[2/1/1995; 8.326.8.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.326.8.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [human services department] health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[2/1/1995; 8.326.8.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.326.10 NMAC, Sections 1 & 3, effective 7/1/2024.

8.326.10.1 ISSUING AGENCY: [~~Human Services Department~~] New Mexico Health Care Authority.
[8.326.10.1 NMAC - Rp, 8.326.10.1 NMAC, 4/1/2021; A, 7/1/2024]

8.326.10.3 STATUTORY AUTHORITY: Subsection E of Section 9-23-6 NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.326.10.3 NMAC - Rp, 8.326.10.3 NMAC, 4/1/2021; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.350.2 NMAC, Sections 1 & 3, effective 7/1/2024.

8.350.2.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.350.2.1 NMAC - Rp, 8.350.2.1 NMAC, 8/1/2014; A, 7/1/2024]

8.350.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health

care programs are administered pursuant to regulations promulgated by the federal department of health and human services under title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.350.2.3 NMAC - Rp, 8.350.2.3 NMAC, 8/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.350.3 NMAC, Sections 1 & 3, effective 7/1/2024.

8.350.3.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[2/1/1995; 8.350.3.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.350.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [human services department] health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[2/1/1995; 8.350.3.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.350.4 NMAC, Sections 1 & 3, effective 7/1/2024.

8.350.4.1 ISSUING AGENCY: [~~New Mexico Human Services Department~~] New Mexico Health Care Authority.
[1/1/1995; 8.350.4.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 1/1/2003; A, 7/1/2024]

8.350.4.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state [human services department] health care authority pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq. (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[1/1/1995; 8.350.4.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 1/1/2003; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.351.2 NMAC, Sections 1 & 3, effective 7/1/2024.

8.351.2.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.351.2.1 NMAC - Rp, 8.351.2.1 NMAC, 1/1/2014; A, 7/1/2024]

8.351.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.351.2.3 NMAC - Rp, 8.351.2.3 NMAC, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.352.2 NMAC, Sections 1 & 3, effective 7/1/2024.

8.352.2.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority.
[8.352.2.1 NMAC - Rp, 8.352.2.1 NMAC, 6/15/2014; A, 7/1/2024]

8.352.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.352.2.3 NMAC - Rp, 8.352.2.3 NMAC, 6/15/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.352.3 NMAC, Sections 1 & 3, effective 7/1/2024.

8.352.3.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority. [8.352.3.1 NMAC - N, 1/1/2014; A, 7/1/2024]

8.352.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-2-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. [8.352.3.3 NMAC - N, 1/1/2014; A, 7/1/2024]

HUMAN SERVICES DEPARTMENT

This is an amendment to 8.354.2 NMAC, Sections 1 & 3, effective 7/1/2024.

8.354.2.1 ISSUING AGENCY: [~~New Mexico Human Services Department (HSD)~~] New Mexico Health Care Authority. [8.354.2.1 NMAC - Rp, 8.354.2.1 NMAC, 8/1/2014; A, 7/1/2024]

8.354.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. [8.354.2.3 NMAC - Rp, 8.354.2.3 NMAC, 8/1/2014; A, 7/1/2024]