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New Mexico Register

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Notices of Rulemaking and Proposed Rules

HEALTH CARE AUTHORITY
DIVISION OF HEALTH IMPROVEMENT

NOTICE OF PUBLIC HEARING

The New Mexico Health Care Authority Division of Health Improvement is finalizing repeal and replacement of the temporary emergency rule 8.370.3 NMAC Health Facility Licensing Fees and Procedures.
These regulations apply to any health facility as defined by Subsection D of 24-1-2 NMSA 1978, as amended, which is licensed or is required to be licensed, or any health facility which by federal regulations must be licensed to obtain or maintain federal funding. The purpose of these regulations is to set licensing fees for health facilities, add the ability to accept electronic payment of fees, update language, incorporate standardized rule language, correcting citation format. Fees are charged in order to partially defray the cost to the state of New Mexico of the licensing process, including the cost of on-site facility surveys by the licensing authority.

Specifically, the changes include:

8.370.3 NMAC

Repeal/replace the expiring emergency rule to establish new update rule to comply with federal regulations as well as NMAC rule requirements. (Specifically, updated sections include: 7, 10, 11 & 12)

A public hearing to receive testimony on this proposed rule will be held on December 20, 2024, 11:00 a.m-12:00 p.m. The public hearing will be a Hybrid, via Zoom as well as in person, pursuant to Section 14-4-5.6 NMSA 1978.
Join on your computer, mobile app, or room device

Please click the link below to join the webinar:
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International numbers available: https://us02web.zoom.us/u/kcZxNhTxC

All written comment may be dropped off during the scheduled hearing time (see above) at the Division of Health Improvement offices, at the Hozho conference room #109, 5300 Homestead Rd. NE, Albuquerque NM 87110.

Individuals wishing to testify may contact the Division of Health Improvement (DHI), P.O. Box H, Santa Fe, NM 87504, or by calling (505) 476-9093.

Individuals who do not wish to attend the hearing may submit written or recorded comments. Written or recorded comments must be received by 5:00 p.m. on the date of the hearing, December 20, 2024. Please send comments to: Division of Health Improvement P.O. Box H Santa Fe, NM 87504, Recorded comments may be left at (505) 476-9093. You may send comments electronically to: dhi.hearingrequest@doh.nm.gov. Written and recorded comments will be posted to the agency's website within 3 days of receipt. All comments will be given the same consideration as oral testimony made at the public hearing.

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TITLE 8 SOCIAL SERVICES
CHAPTER 370 OVERSIGHT OF LICENSED HEALTHCARE FACILITIES AND COMMUNITY BASED WAIVER PROGRAMS
PART 3 HEALTH FACILITY LICENSURE FEES AND PROCEDURES

8.370.3.1 ISSUING AGENCY: New Mexico Health Care Authority, Division of Health Improvement, Health Facility Licensing and Certification Bureau. [8.370.3.1 NMAC - Rp, 8.370.3.1 NMAC, 1/28/2025]

8.370.3.2 SCOPE: These regulations apply to any health facility as defined by Subsection D of Section 24-1-2 NMSA 1978, as amended, which is licensed or is required to be licensed, or any health facility which by federal regulations must be licensed to obtain or maintain

federal funding.
[8.370.3.2 NMAC - Rp, 8.370.3.2 NMAC, 1/28/2025]

8.370.3.3
STATUTORY AUTHORITY: The regulations set forth herein have been promulgated by the secretary of the New Mexico health care authority (authority), pursuant to the general authority granted under Subsection E of Section 9-8-6 of the Health Care Authority Act, NMSA 1978, as amended; and the authority granted under Subsection D of Section 24A-1-2, Subsection I of Section 24A-1-3, and Section 24A-1-5 of the Health Care Code, NMSA 1978, as amended. 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 purchasing and regulation.
[8.370.3.3 NMAC - Rp, 8.370.3.3 NMAC, 1/28/2025]

8.370.3.4
DURATION: Permanent.
[8.370.3.4 NMAC - Rp, 8.370.3.4 NMAC, 01/28/2025]

8.370.3.5
EFFECTIVE DATE: January 28, 2025, unless a later date is cited at the end of a section.
[8.370.3.5 NMAC - Rp, 8.370.3.5 NMAC, 1/28/2025]

8.370.3.6
OBJECTIVE: The purpose of these regulations is to set licensing fees for health facilities. Fees are charged in order to partially defray the cost to the state of New Mexico of the licensing process, including the cost of on-site facility surveys by the licensing authority.
[8.370.3.6 NMAC - Rp, 8.370.3.6 NMAC, 1/28/2025]

8.370.3.7
DEFINITIONS: For purposes of these regulations the following shall apply:

A. Definitions beginning with "A"

(1) "amended license" means a license issued by the licensing authority to reflect a non-substantive change which does not result in the voiding of the original license, for example, a change in the name of the facility or a change in the operator or administrator;

(2) "annual license" is a license granting permission to operate a facility for the one-year period stated on the face of the document; the annual license is issued on an initial and renewal basis following submission of an acceptable application for license and survey of the facility;

(3) "application for license" means the forms, attachments and other writings and drawings required by the licensing authority, under the authority of the regulations listed in 8.370.3.14 NMAC, of these regulations to be submitted for review by the licensing authority as part of the process of granting or denying an annual license;

B. Definitions beginning with "B": "bed" means an assembly for sleeping, whether or not the bed is in actual use and for which "bed capacity" the facility is licensed;

C. Definitions beginning with "C"

(1) "capacity" means the total number of persons or beds for which the facility is licensed;

(2) "certificate of compliance (COC) &certificate of accreditation (COA)" are all tests performed are moderate or high complexity and must meet the non-waived requirements under 42 CFR part 493. These laboratories are inspected every 2 years.

(3) "certificate for provider performed microscopy (PPMP) are tests performed under this certificate type are limited to 9 tests using a light microscope and the tests categorized as waived by the FDA. The microscopy tests are not waived because they require training and skill. These tests may only be performed by a licensed Medical Doctor, Doctor of Osteopathy, Dentist, Doctor of Podiatry, Physician's Assistant or a Certified Nurse Practitioner. These tests must also be performed during the patient's visit. All requirements for moderate complexity testing must be met.

(4) "certificate of waiver" are laboratories, such as your physician office, performs simple tests cleared by the Food & Drug Administration as "waived." Most of these tests require samples that do not require processing such as whole blood, throat swab, saliva or urine. These laboratories must follow all instructions by the manufacturer

(5) "change of ownership" licenses are **non-transferable**; a change of ownership licensure will follow the initial application and licensure fee schedule process;

(6) "clinical laboratory improvement amendments (CLIA)" of 1988 are United States Federal Regulatory standards that apply to all clinical laboratory testing performed on humans in the United States, except clinical trials and basic research.

D. Definitions beginning with "D": "denial of the license" means action by the licensing authority refusing to grant an annual license on the basis of non-compliance with applicable laws and regulations, and specifically under these regulations, nonpayment of the prescribed fee;

E. Definitions beginning with "E" [RESERVED]

F. Definitions beginning with "F"

(1) "facility and health facility" means any health facility required to be licensed by the licensing authority by authority of the Health Care Code, Sections 24A-1-1 et. seq. NMSA 1978, as amended, and the regulations listed in 8.370.3.14 NMAC of these regulations;

(2) "facility inspections or survey and inspection survey" means an entry into a facility and examination of the facility premises, inspection of records and interview of staff and clientele;

(3) "for profit facility" means a facility whose primary goal is to earn a profit.

G. Definitions beginning with "G" [RESERVED]

H. Definitions beginning with "H" [RESERVED]

I. Definitions beginning with "I" [RESERVED]

J. Definitions beginning with "J" [RESERVED]

K. Definitions beginning with "K" [RESERVED]

L. Definitions beginning with "L"

(1) "license" means the document issued by the licensing authority which authorizes the operation of a facility. The term license may mean an annual license or a time-limited temporary license;

(2) "licensing authority" means the division of health improvement of the New Mexico department of health;

M. Definitions beginning with "M" [RESERVED]

N. Definitions beginning with "N": "non-profit facility" means a facility that operates for charitable or socially beneficial purposes rather than to make a profit.

O. Definitions beginning with "O" [RESERVED]

P. Definitions beginning with "P": "private equity facility" is a healthcare facility that has been purchased by a private equity firm or investment management company using investor money and debt that provides financial backing and makes investments in the private equity of startup or operating companies through a variety of loosely affiliated investment strategies including leveraged buyout, venture capital, and growth capital.

Q. Definitions beginning with "Q" [RESERVED]

R. Definitions beginning with "R" [RESERVED]

S. Definitions beginning with "S": "state owned facility" means a health facility licensed by the division of health improvement which is owned by the state.

T. Definitions beginning with "T": "temporary license" means a provisional license granting permission to operate a facility for any period of time not to exceed one hundred twenty (120) days; not more than two (2) consecutive temporary licenses may be granted by the licensing authority.

[8.370.3.7 NMAC - Rp, 8.370.3.7 NMAC, 1/28/2025]

8.370.3.8 STANDARD OF COMPLIANCE: Strict compliance is required of health facilities subject to these regulations. Payment of the licensing fee is a condition precedent to licensure of the health facility by the licensing authority.

[8.370.3.8 NMAC - Rp, 8.370.3.8 NMAC, 1/28/2025]

8.370.3.9 BASIS: Licensing fees for inpatient health facilities providing professional medical or nursing services on a 24 hour basis are based upon a maximum fee per bed set by statute. Licensing fees are based upon the maximum fee for health facilities as set by statute.

[8.370.3.9 NMAC - Rp, 8.370.3.9 NMAC, 1/28/2025]

8.370.3.10 LICENSURE FEE SCHEDULE: Rates shall be charged, as indicated in the fee schedule shown in this section, upon initial and renewal application for an annual license and prior to issuance of a second temporary license. The fee for the first temporary license is included in the initial application fee. This rule applies to both initial and renewal of health facility licenses.

A. hospitals: general hospitals, limited hospitals, children's psychiatric hospitals, special hospitals to include orthopedic, children's, psychiatric, alcohol & drug abuse treatment, rehabilitation, and other special hospital as identified

Facility Types:	**Rate Per License**	**Term limit**
Hospital bed rate	$12.00 per bed	Annually

B. Assisted living facilities

Facility Types:	**Rate Per License**	**Term limit**
Assisted living base assessment rate	$300.00	Annually

C. Long-term care facilities

Facility Types:	**Rate Per License**
skilled nursing facilities	$12.00 per bed
intermediate care facilities	$12.00 per bed
intermediate care facilities for mentally retarded	$12.00 per bed

D. Outpatient health facilities:

Facility Types:	Rate Per License
Health facilities providing outpatient medical services	$300.00
community mental health centers	$300.00
free standing hospice	$300.00
home health agency	$300.00
diagnostic and treatment center	$300.00
limited diagnostic and treatment center	$300.00
rural health clinic	$300.00
Infirmary	$300.00
new or innovative clinic	$300.00
ambulatory surgical center	$300.00

E. Other health facilities

Facility Types:	Rate Per License
Facilities providing services for end stage renal disease	$300.00
services for end state renal disease	$300.00
renal transplantation center	$300.00
renal dialysis center	$300.00
renal dialysis facility	$300.00
self dialysis unit	$300.00
special purpose renal dialysis facility	$300.00
In home and inpatient hospice care	$300.00
Home health agencies	$300.00
Rural emergency hospital	$300.00
Freestanding birth centers	$300.00
Adult accredited residential treatment center	$600.00 bi-annually + $25 per bed
Boarding homes	$300.00

F. Adult Day Care: Facilities providing adult day care and services for less than 24 hours a day for three or more clients in accordance with 8.370.20 NMAC

Facility Types:	Rate Per License
Adult day care facilities	$300.00

[8.370.3.10 NMAC - Rp, 8.370.3.10 NMAC, 1/28/2025]

8.370.3.11 FEES FOR AMENDED LICENSES: The licensing fee for each amended license issued shall be $300.00 as follows:

Amendment Type:	Amended License Fee:
Change of administrator or director	$300.00
Change of capacity (additional $25.00 per bed if fee is rate per bed)	$300.00
Change of facility name	$300.00
Change of physical address	$300.00

[8.370.3.11 NMAC - Rp, 8.370.3.11 NMAC, 1/28/2025]

8.370.3.12 METHOD OF PAYMENT FOR LICENSE FEES: All applications for license and requests for amended license shall be accompanied by the prescribed fee in the form of a check or money order or state approved electronic payment process payable to the State of New Mexico or the health care authority.
[8.370.3.12 NMAC - Rp, 8.370.3.12 NMAC, 1/28/2025]

8.370.3.13 NON-REFUNDABLE PRE-PAYMENT OF FEES: All fees are prepaid and are not refundable.
[8.370.3.13 NMAC - Rp/E, 8.370.3.13 NMAC, 1/28/2025]

8.370.3.14 RELATED REGULATIONS: The following is a list of regulations regarding licensure of health facilities within the jurisdiction of the licensing authority.

A. Requirements for acute care, limited services and special hospitals, New Mexico health care authority, 8.370.12 NMAC.

B. Requirements for long term care facilities, New Mexico health care authority, 8.370.16 NMAC

C. Requirements for facilities providing outpatient medical services and infirmaries, New Mexico health care authority, 8.370.18 NMAC.

D. Requirements for in-home and inpatient hospice care, New Mexico health care authority, 8.370.19 NMAC

E. Requirements for adult day care facilities, New Mexico health care authority, 8.370.20 NMAC.

F. Requirements for intermediate care facilities for the mentally retarded, New Mexico health care authority, 8.371.2 NMAC.

G. Requirements for end stage renal disease facilities, New Mexico health care authority, 8.370.24 NMAC.

H. Requirements for assisted living facilities for Adults, New Mexico health care authority, 8.370.14 NMAC.

I. Requirements for home health agencies, New Mexico health care authority, 8.370.22 NMAC.

J. Requirements for rural emergency hospitals, New Mexico health care authority, 8.370.13 NMAC.

K. Requirements for boarding homes, New Mexico health care authority, 8.370.15 NMAC.

L. Requirements for clinical laboratory improvement amendments, 42 CFR, Part 493, New Mexico health care authority.

M. Requirements for community mental health centers, New Mexico health care authority, 8.321.6 NMAC

N. Requirements for freestanding birth centers, New Mexico health care authority, 8.370.17 NMAC

O. crisis triage centers, New Mexico health care authority, 8.321.11 NMAC
[8.370.3.14 NMAC - Rp, 8.370.3.14 NMAC, 1/28/2025]

History of 8.370.3 NMAC: [RESERVED]

HISTORY OF 7.1.7 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the state records center:
HED-85-7 (HSD), Regulations Governing Licensing Fees for Health Facilities, filed 11/20/1985.
DOH 91-3 (PHD), New Mexico Regulations Governing Licensing Fees for Health Facilities, filed 10/18/1991.
DOH 93-3 (PHD), Regulations Governing Licensing Fees for Health Facilities in New Mexico, filed 4/30/1993.

History of Repealed Material:
7.1.7 NMAC, Health Facility Licensure Fees and Procedures (filed 2/15/2006) repealed effective 12/01/2010.
8.370.3.1 NMAC, Health Facility Licensure Fees and Procedures (filed 8/1/2024) repealed effective 1/28/2025.

Other History:
DOH 93-3 (PHD), Regulations Governing Licensing Fees for Health Facilities in New Mexico (filed 4/30/1993) was renumbered, reformatted, amended and replaced by 7 NMAC 1.7, Health Facility Licensure Fees and Procedures, effective 10/31/1996.
7 NMAC 1.7, Health Facility Licensure Fees and Procedures (filed 10/18/1996) was renumbered, reformatted, amended and replaced by 7.1.7 NMAC, Health Facility Licensure Fees and Procedures, effective 2/28/2006.
7.1.7 NMAC, Health Facility Licensure Fees and Procedures (filed 2/15/2006) was replaced by 7.1.7 NMAC, Health Facility Licensure Fees and Procedures, effective 12/01/2010.
8.370.3 NMAC, Health Facility Licensure Fees And Procedures filed 8/1/2024 was replaced by 8.370.3 NMAC, Health Facility Licensure Fees And Procedures, effective 1/28/2025.

HEALTH CARE AUTHORITY
DIVISION OF HEALTH IMPROVEMENT

NOTICE OF PUBLIC HEARING

The New Mexico Health Care Authority Division of Health Improvement is finalizing amendments to the caregivers criminal history screening requirements to include the removing the previous specific fee amount to complete the screening and applies the actual costs incurred by the authority. It also updates the notification process to include the use of updated electronic communication methods and removes the requirement to use certified mail.
Specifically, the changes include:

8.370.5 NMAC

This is an amendment to 8.370.5 NMAC Section 8 and Section 9 effective 1/28/2025.

8.370.5.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS:

A. General: The responsibility for compliance with the requirements of the act applies to both the care provider and to all applicants, caregivers and hospital caregivers. All applicants for employment to whom an offer of employment is made or caregivers and hospital caregivers employed by or contracted

to a care provider must consent to a nationwide and statewide criminal history screening, as described in Subsections D, E and F of this section, upon offer of employment or at the time of entering into a contractual relationship with the care provider. Care providers shall submit all fees and pertinent application information for all applicants, caregivers or hospital caregivers as described in Subsections D, E and F of this section. Pursuant to Section 29-17-5 NMSA 1978 (amended) of the act, a care provider's failure to comply is grounds for the state agency having enforcement authority with respect to the care provider to impose appropriate administrative sanctions and penalties.

B. Exception: A caregiver or hospital caregiver applying for employment or contracting services with a care provider within 12 months of the caregiver's or hospital caregiver's most recent nationwide criminal history screening which list no disqualifying convictions shall only apply for a statewide criminal history screening upon offer of employment or at the time of entering into a contractual relationship with the care provider. At the discretion of the care provider a nationwide criminal history screening, additional to the required statewide criminal history screening, may be requested.

C. Conditional employment: Applicants, caregivers, and hospital caregivers who have submitted all completed documents and paid all applicable fees for a nationwide and statewide criminal history screening may be deemed to have conditional supervised employment pending receipt of written notice given by the authority as to whether the applicant, caregiver or hospital caregiver has a disqualifying conviction.

D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the authority on forms provided by the authority.

(1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 8.370.5.8 NMAC.

(2) A signed authorization for release of information form.

(3) Three complete sets of readable fingerprint cards or other authority approved media acceptable to the department of public safety and the federal bureau of investigation submitted using black ink.

(4) The fee specified by the authority for the nationwide and statewide criminal history screening investigation [~~shall not exceed $74. Of which, $24 shall be applied for the federal bureau of investigation nationwide criminal history screening, seven dollars shall be applied for the statewide criminal history screening. The remaining application fee~~] shall be applied to cover costs incurred by the authority to support activities required by the act and these rules. The fees will not be applied to any other activity or expense undertaken by the authority.

(5) If the applicant, caregiver or hospital caregiver must submit another readable set of fingerprint cards upon notice that the fingerprint cards previously submitted were found unreadable, as determined by the federal bureau of investigation or department of public safety, the submission of a second set of fingerprint cards is required, a separate fee will not be charged. A fee shall be charged for submission of a third and subsequent fingerprint sets.

(6) If the applicant, caregiver or hospital caregiver has a physical or medical condition which prevents the applicant, caregiver or hospital caregiver from producing readable fingerprints using commonly available fingerprinting techniques, the applicant, caregiver or hospital caregiver shall submit the fingerprint cards with a notarized affidavit signed by the applicant, caregiver, hospital caregiver, returned to the authority within 14 calendar days, as determined by the postmark, which provides:

(a) identification of the applicant, caregiver or hospital caregiver; and

(b) an explanation of, or a statement describing, the applicant's, caregiver's or hospital caregiver's good faith efforts to supply readable fingerprints; and

(c) the physical or medical reason that prevents the applicant, caregiver or hospital caregiver from producing readable fingerprints using commonly available fingerprinting techniques;

(d) an applicant, caregiver or hospital caregiver meeting the conditions of this paragraph and who has resided in the state of New Mexico for less than 10 years must also submit a 10 year work history in addition to the required affidavits.

(7) All documentation submitted to the authority for the purposes of criminal history screening and for the purposes set forth in 8.370.5.9 NMAC and 8.370.5.10 NMAC shall become the sole property of the authority with the exception of fingerprint cards which shall be destroyed upon clearance by both the federal bureau of investigation and department of public safety. All other submitted documentation shall be retained by the authority for a period of one year from the final date of closure and thereafter shall be archived.

E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions. The authority and department of public safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the authority prior to or at the same time with the authority's receipt

of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico health care authority or other method of funds transfer acceptable to the authority. Business checks will be accepted unless the business tendering the check has previously tendered a check to the authority unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant, caregiver or hospital caregiver. The authority will set a fee in addition to the fees imposed by department of public safety and the federal bureau of investigation that will fully and completely cover costs incurred by the authority to support activities required by the act and these rules. The fees will not be applied to any other activity or expense undertaken by the authority.

F. Timely submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 8.370.5.7 NMAC, no later than 20 calendar days from the first day of employment or effective date of a contractual relationship with the care provider.

G. Maintenance of records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules.

(1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification.

(2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by (name of care provider)" together with the employee's job description, shall suffice for record keeping purposes.

[8.370.5.8 NMAC - N, 7/1/2024, A, 01/28/2025]

8.370.5.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:

A. Prohibition on employment: A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.

(1) In cases where the criminal history record lists an arrest for a crime that would constitute a disqualifying conviction and no final disposition is listed for the arrest, the authority will attempt to notify the applicant, caregiver or hospital caregiver and request information from the applicant, caregiver or hospital caregiver within timelines set forth in the authority's notice regarding the final disposition of the arrest. Information requested by the authority may be evidence, for example, a certified copy of an acquittal, dismissal or conviction of a lesser included crime.

(2) An applicant's, caregiver's or hospital caregiver's failure to respond within the required timelines regarding the final disposition of the arrest for a crime that would constitute a disqualifying conviction shall result in the applicant's, caregiver's or hospital caregiver's temporary disqualification from employment as a caregiver or hospital caregiver pending written documentation submitted to the authority evidencing the final disposition of the arrest. Information submitted to the authority may be evidence, for example, of the certified copy of an acquittal, dismissal or conviction of a lesser included crime. In instances where the applicant, caregiver or hospital caregiver has failed to respond within the required timelines the authority shall provide notice by [~~certified~~] mail or electronic communication that an employment clearance has not been granted. The care provider shall then follow the procedure of Subsection A of 8.370.5.9 NMAC.

(3) The authority will not make a final determination for an applicant, caregiver or hospital caregiver with a pending potentially disqualifying conviction for which no final disposition has been made. In instances of a pending potentially disqualifying conviction for which no final disposition has been made, the authority shall notify the care provider, applicant, caregiver or hospital caregiver by [~~certified~~] mail or electronic communication that an employment clearance has not been granted. The care provider shall then follow the procedure of Subsection A of 8.370.5.9 NMAC.

B. Employment pending reconsideration determination: At the discretion of the care provider, an applicant, caregiver or hospital caregiver whose nationwide criminal history record reflects a disqualifying conviction and who has requested administrative reconsideration may continue conditional supervised employment pending a determination on reconsideration.

C. Notice of final determination of disqualification: Upon receipt of a notice of final determination of disqualification a care provider shall:

(1) immediately and permanently remove an applicant, caregiver or hospital caregiver from any position of employment that meets the definition of an applicant, caregiver or hospital caregiver as set forth in Subsections D and K of 8.370.5.7 NMAC; and

(2) notify the authority by letter within 14 calendar days, as determined by the postmark,

of the date and type of action taken to satisfy the removal requirements of as set forth in Paragraph (1) of Subsection C of this section via written documentation signed by an authorized agent of the care provider. [8.370.5.9 NMAC - N, 7/1/2024; A, 01/28/2025]

A public hearing to receive testimony on this proposed rule will be held on December 20, 2024, 10:00 a.m-10:50 a.m. The public hearing will be a Hybrid, via Zooms as well as in person, pursuant to Section 14-4-5.6 NMSA 1978.

Join on your computer, mobile app, or room device
When: Dec 20, 2024 10:00 AM Mountain Time (US and Canada)
Topic: Proposed Rule Amendments NMAC 8.370.5

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+1 301 715 8592 US (Washington DC)
+1 305 224 1968 US
+1 309 205 3325 US
+1 312 626 6799 US (Chicago)
+1 360 209 5623 US
+1 386 347 5053 US
+1 507 473 4847 US
+1 564 217 2000 US
Webinar ID: 852 8649 8652
Passcode: 230418
International numbers available: https://us02web.zoom.us/u/kdN3OvRZyX

All written comment may be dropped off during the scheduled hearing time (see above) at the Division of Health Improvement offices, at the Hozho conference room #109, 5300 Homestead Rd. NE, Albuquerque NM 87110.

Individuals wishing to testify may contact the Division of Health Improvement (DHI), P.O. Box H, Santa Fe, NM 87504, or by calling (505) 476-9093.

Individuals who do not wish to attend the hearing may submit written or recorded comments. Written or recorded comments must be received by 5:00 p.m. on the date of the hearing, December 20, 2024. Please send comments to: Division of Health Improvement P.O. Box H Santa Fe, NM 87504, Recorded comments may be left at (505) 476-9093. You may send comments electronically to: dhi.hearingrequest@doh.nm.gov. Written and recorded comments will be posted to the agency's website within 3 days of receipt. All comments will be given the same consideration as oral testimony made at the public hearing.

If you are a person with a disability and you require this information in an alternative format, or you require a special accommodation to participate in any HSD public hearing, program, or service, please contact the American Disabilities Act Coordinator, at Office-505-709-5468, Fax-505-827-6286 or through the New Mexico Relay system, toll free at #711. The Department requests at least a 10-day advance notice to provide requested alternative formats and special accommodations.

PUBLIC SCHOOL FACILITIES AUTHORITY

NOTICE OF PROPOSED RULEMAKING

Public Hearing. The New Mexico Public School Facilities Authority (PSFA) gives notice that it will conduct a public hearing located at the UNM Science and Technology Park Auditorium, 800 Bradbury Dr. SE Albuquerque, NM, 87106, on Thursday, December 19, 2024 from 10:00 a.m. to 12:00 p.m. (MDT). The purpose of the public hearing is to receive public input on the proposed repealing and replacing 6.27.30 NMAC, Statewide Adequacy Standards. At the hearing, the PSFA will provide a verbal summary statement on record. Attendees who wish to provide public comment on record will be given five (5) minutes to make a statement regarding the rule changes. Written comment will also be accepted at the hearing.

Explanation of Purpose and Summary of Text.
As the New Mexico public school statewide adequacy standards are dynamic, the purpose of the proposed amendment to rule 6.27.30 NMAC is to ensure that updates to space and attributes needed to support educational and technology programs and curricula, defined and justified as required by public education department standards and benchmarks are incorporated into the adequacy standards as time and circumstances require.

Statutory Authorizations:
Sections 22-24-1 through 22-24-11 NMSA 1978

Stakeholder Engagement.
Stakeholder engagement regarding this proposed rule change was held. PSFA conducted statewide workshops with school districts and the architecture and engineering community in 2021 to explain the purpose of the standards and gather feedback regarding potential changes from these stakeholders.

Public Comment. Interested parties may provide comment at the public hearing or may submit written comments by mail to Alyce Ramos, Programs Manager, Public School Facilities Authority, 1312 Basehart SE, Suite 200, Albuquerque, NM 87106, by electronic mail to aramos@nmpsfa.org. All written comments must be received no later than 5:00 p.m. (MDT) on December 20, 2024. The PSFA encourages the early submission of written comments. The public comment period is from November 20, 2024 to December 20, 2024 at 5:00 p.m. (MDT). The PSFA will review all feedback received during the public comment period and issue communication regarding final decision at a later date.

Copies of the proposed new rule may be accessed via PSFA's home page under the "Notice of Rulemaking" section http://nmpsfa.org, or may be obtained from Alyce Ramos at (505) 468-0299 during regular business hours.

Individuals with disabilities who require the above information in an alternative format, or who need any form of auxiliary aid to attend or participate in the public hearing are asked to contact Alyce Ramos at (505) 468-0299 as soon as possible before the date set for the public hearing. The PSFA requires at least ten (10) calendar days advance notice to provide any special accommodations requested.

TAXATION AND REVENUE, DEPARTMENT OF

NOTICE OF PROPOSED RULEMAKING

The New Mexico Taxation and Revenue Department hereby gives notice as required under Section 14-4-5.2 NMSA 1978 and 1.24.25.11 NMAC that it proposes to amend/repeal/replace and/or enact certain rules and regulations pertaining to the Gross Receipts and Compensating Tax Act and certain business tax credits. The State Records Center and Archives Administrative Law Division is requiring a repeal and replace of the entire regulation part Title 3: Taxation, Chapter 3: Business Tax Credits, Part 1: General Provisions in order to make this amendment, citing Regulation Subsection C of 1.24.11.9 NMAC.

Summary of Proposed Changes: The New Mexico Taxation and Revenue Department proposes to amend and enact the following rule(s):

Imposition of Gross Receipts and Compensating Tax Act
For ease of reference these changes are shown as amendments, see below on where to locate copies of the proposed rules:

Section 7-9-3.5 NMSA 1978
3.2.1.18 - Gross Receipts: Services Generally (Amend)

Section 7-9A-1 NMSA 1978
3.13.1.1 - Issuing Agency (Repeal and Replace)
3.13.1.2 - Scope (Repeal and Replace)
3.13.1.3 - Statutory Authority (Repeal and Replace)
3.13.1.4 - Duration (Repeal and Replace)
3.13.1.5 - Effective Date (Repeal and Replace)
3.13.1.6 - Objective (Repeal and Replace)
3.13.1.7 - Definition (Repeal and Replace)
3.13.1.8 - Citation of Statutes (Repeal and Replace)

No Statutory Reference - Credit no longer exists
3.13.3.1 - Issuing Agency (Repeal)
3.13.3.2 - Scope (Repeal)
3.13.3.3 - Statutory Authority (Repeal)
3.13.3.4 - Duration (Repeal)
3.13.3.5 - Effective Date (Repeal)
3.13.3.6 - Objective (Repeal)
3.13.3.7 - Definition (Repeal)
3.13.3.8 - Reserved (Repeal)
3.13.3.9 - Reserved (Repeal)
3.13.3.9 - Reserved (Repeal)

Technical Information: No technical information was consulted in drafting these proposed rule changes.

Purpose of Proposed Rule: The proposed repeal and replace is in accordance with the SRCA requirements. The regulation changes to Regulation 3.2.1.18 NMAC are to match current statutory references and make a grammatical correction. The changes to Regulation 3.13.1 NMAC are to make the language more generic to cover any tax credit regulation needed under this part. Regulation 3.13.3 NMAC is being repealed as this credit no longer exists.

Notice of Public Rule Hearing: A public hearing will be held on the proposed rule changes on Thursday, December 19th, 2024, from 9AM to 10AM at the 3rd floor in the Montoya Building, 1100 South St. Francis Drive, Santa Fe, New Mexico 87504. The hearing will be recorded, and oral comments can be made during the public hearing. Written comments can be submitted as outlined at the end of this notice.

Virtual meeting access also available using Microsoft Teams:
https://teams.microsoft.com/l/meetup-join/19%3ameeting_ZGU4YTk5ZWUtMWYyZC00OTE2LTgyMWYtMTYxYTAzZGE2MDMw%40thread.v2/0?context=%7b%22Tid%22%3a%2204aa6bf4-d436-426f-bfa4-04b7a70e60ff%22%2c%22Oid%22%3a%22124fc7fc-ea47-4a9a-84d4-010bcce6239a%22%7d
Meeting ID: 263 008 840 973
Passcode: 6Yu49o

Dial in by phone
+1 505-312-4308 Phone conference ID: 762 250 225#

The rule proposals were placed on file in the Office of the Secretary on *November* 4th, 2024. Pursuant to Regulation 3.1.2.9 NMAC under Section 9-11-6.2 NMSA 1978 of the Taxation and Revenue Department Act, the final of the proposals, if filed,

will be filed as required by law on or about January 3, 2025.

Individuals with disabilities who need any form of auxiliary aid to attend or participate in the public hearing are asked to contact the Tax Information and Policy Office at policy.office@tax.nm.gov. The Taxation and Revenue Department will make every effort to accommodate all reasonable requests but cannot guarantee accommodation of a request that is not received at least ten calendar days prior to the scheduled hearing.

Copies of the proposed rules may be found at: https://www.tax.newmexico.gov/all-nm-taxes/proposed-regulations-hearing-notices/ or are available upon request by contacting the Tax Policy Office at policy.office@tax.nm.gov.

Notice of Acceptance of Written Public Comment: Written comments on the proposals can be submitted by email to policy.office@tax.nm.gov or by mail to the Taxation and Revenue Department, Tax Information and Policy Office, Post Office Box 630, Santa Fe, New Mexico 87504-0630 on or by 5PM on Thursday, December 19th , 2024.

All written comments received by the agency will be posted on https://www.tax.newmexico.gov/all-nm-taxes/proposed-regulations-hearing-notices/ no more than 3 business days following receipt to allow for public review.

End of Notices of Rulemaking and Proposed Rules

Adopted Rules

Effective Date and Validity of Rule Filings

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

CHILDREN, YOUTH AND FAMILES DEPARTMENT

The Children, Youth and Families Department with rulemaking authority is approving a repeal of its rule 8.8.3 NMAC – GOVERNING BACKGROUND CHECKS AND EMPLOYMENT HISTORY, filed 10/01/2016 and replaced with 8.8.3 NMAC GOVERNING BACKGROUND CHECKS AND EMPLOYMENT HISTORY, adopted 11/19/2024 and effective 11/20/2024

CHILDREN, YOUTH AND FAMILES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 8 CHILDREN, YOUTH AND FAMILIES GENERAL PROVISIONS
PART 3 GOVERNING BACKGROUND CHECKS AND EMPLOYMENT HISTORY VERIFICATION

8.8.3.1 ISSUING AGENCY: Children, Youth and Families Department.
[8.8.3.1 NMAC - Rp, 8.8.3.1 NMAC, 11/20/2024]

8.8.3.2 SCOPE: This rule applies to CYFD-contracted, direct care providers and their employees, sub-contractors, volunteers, and student interns. This rule applies to all operators, employees, and volunteers; and prospective operators, employees, and volunteers of all CYFD-contracted programs and facilities that have primary custody of children for 20 hours or more per week, including juvenile treatment facilities.
[8.8.3.2 NMAC - Rp, 8.8.3.2 NMAC, 11/20/2024]

8.8.3.3 STATUTORY AUTHORITY: The statutory authority for these rules is contained in the Criminal Offender Employment Act Section 28-2-1 NMSA 1978 to 28-2-6 NMSA 1978 and in the New Mexico Children's and Juvenile Facility Criminal Records Screening Act Section 32A-15-1 NMSA 1978 to 32A-15-4 NMSA 1978.
[8.8.3.3 NMAC - Rp, 8.8.3.3 NMAC, 11/20/2024]

8.8.3.4 DURATION: Permanent
[8.8.3.4 NMAC - Rp, 8.8.3.4 NMAC, 11/20/2024]

8.8.3.5 EFFECTIVE DATE: November 20, 2024, unless a later date is cited at the end of a section.
[8.8.3.5 NMAC - Rp, 8.8.3.5 NMAC, 11/20/2024]

8.8.3.6 OBJECTIVE:

A. The purpose of these rules is to set out general provisions regarding background checks and employment history verification required in settings to which these rules apply.

B. Background checks are conducted to identify information in applicants' backgrounds bearing on whether they are eligible to provide services in settings to which these rules apply.

C. Abuse and neglect screens of databases in New Mexico are conducted by CYFD Background Check Unit (BCU) employees to identify those persons who pose a threat of abuse or neglect to care recipients in settings to which these rules apply.
[8.8.3.6 NMAC - Rp, 8.8.3.6 NMAC, 11/20/2024]

8.8.3.7 DEFINITIONS:

A. "Administrative review" means an informal process of reviewing a decision that may include an informal conference, hearing, or a review of written records.

B. "Administrator" means the manager in charge of the day-to-day operation of a facility. The administrator may be the licensee or an authorized representative of the licensee and be at least 18 years of age.

C. "Adult" means a person who has a chronological age of 18 years or older, except for persons under Medicaid certification up to the age of 21.

D. "Appeal" means a review of a determination made by the BCU, which may include a record review or a hearing.

E. "Applicant" means any person who is required to obtain a background check under these rules and Section 32A-15-3 NMSA 1978.

F. "Arrest" means notice from a law enforcement agency about an alleged violation of law.

G. "Background check" means a screen of CYFD's information databases, state and federal criminal records, and any other reasonably reliable information about an applicant.

H. "Care recipient" means any person under the care of a licensee.

I. "Child" means a person who has a chronological age of less than 18 years, and persons under applicable Medicaid certification up to the age of 21 years.

J. "Criminal history" means information possessed by law enforcement agencies of arrests, indictments,

or other formal charges, as well as dispositions arising from these charges.

K. "Direct, physical supervision" means continuous visual contact or live video observation by a direct care provider who has been found eligible by a background check of an applicant during periods when the applicant is in immediate physical proximity to care recipients.

L. "Direct care provider" means any individual who, as a result of employment, contractual service, or volunteer service (including student interns) has direct care responsibilities or potential unsupervised physical or virtual access to any child or care recipient in the settings to which these rules apply.

M. "Eligibility" means the determination that an applicant does not pose an unreasonable risk to care recipients after a background check is conducted.

N. "Employment history" means a written summary of the most recent three-year period of employment with names, addresses, and telephone numbers of employers, including dates of employment, stated reasons for leaving employment, and dates of all periods of unemployment with stated reasons for periods of unemployment, and verifying references.

O. "Licensed" means authorized to operate by the licensing authority by issuance of an operator's license or certification certificate.

P. "Licensee" means the holder of, or applicant for, a license, certification, or registration pursuant to 7.20.11 NMAC, 7.20.12 NMAC, 7.8.3 NMAC, or other program or entity within the scope of these rules.

Q. "Licensing authority" means CYFD or entity having authority over the licensee.

R. "Relevant conviction" means a plea, judgment or verdict of guilty, no contest, nolo contendere, conditional plea of guilty, or any other plea that would result in a conviction for a crime in a court of law in New Mexico or any other state. The term "Relevant Conviction" also includes decrees adjudicating juveniles as serious youthful offenders or youthful offenders, or convictions of children who are tried as adults for their offenses. Successful or pending completion of a conditional discharge under Section 31-20-13 NMSA 1978, or Section 30-31-28 NMSA 1978, or a comparable provision of another state's law, is not a relevant conviction for purposes of these rules, unless or until such time as the conditional discharge is revoked or rescinded by the issuing court. The term "Relevant Conviction" does not include any of the foregoing if a court of competent jurisdiction has overturned the conviction or adjudicated decree and no further proceedings are pending in the case or if the applicant has received a legally effective executive pardon for the conviction. The burden is on the applicant to show that the applicant has a pending or successful completion of any conditional discharge or consent decree or that the relevant conviction has been overturned on appeal or has received a legally effective pardon.

S. "Unreasonable risk" means the level of risk that a reasonable person would be unwilling to take with the safety or welfare of care recipients.

[8.8.3.7 NMAC - Rp, 8.8.3.7 NMAC, 11/20/2024]

8.8.3.8 APPLICABILITY: These rules apply to all licensees and direct care providers in the following settings:

A. behavior management skills development;

B. case management services;

C. group home services;

D. day treatment services;

E. residential treatment services;

F. treatment foster care services agencies;

G. licensed shelter care;

H. comprehensive community support services;

I. contractors and any programs or facilities receiving CYFD funding or reimbursement; and

J. supervised visitation and safe exchange programs.

[8.8.3.8 NMAC - Rp, 8.8.3.8 NMAC, 11/20/2024]

8.8.3.9 NON-APPLICABILITY:

A. These rules do not apply to the following settings, except when otherwise required by applicable certification requirements for child and adolescent behavioral health services 7.20.11 NMAC or to the extent that such a program receives funding or reimbursement from CYFD:

(1) hospitals or infirmaries;

(2) intermediate care facilities;

(3) children's psychiatric centers;

(4) home health agencies;

(5) diagnostic and treatment centers; and

(6) childcare centers and homes.

B. These rules do not apply to the following adults:

(1) treatment foster care parents;

(2) relative care providers who are not otherwise required to be licensed or registered;

(3) foster grandparent volunteers; and

(4) all other volunteers for any program or entity within the scope of these rules if the volunteer spends less than six hours per week at the program, is under direct physical supervision, and is not counted in the facility ratio.

[8.8.3.9 NMAC - Rp, 8.8.3.9 NMAC, 11/20/2024]

8.8.3.10 COMPLIANCE:

A. Compliance with these rules is a condition of licensure, registration, certification or renewal, or continuation of same or participation in any other program or contract within the scope of these rules.

B. The licensee is required to:

(1) submit an electronic fingerprint submission receipt and the required forms for all direct care providers, or any employee, contractor, volunteer, or student intern present while care recipients are present, or other adult as required by the applicable rules prior to the commencement of service, whether as employee, contractor, or volunteer;

(2) verify the employment history of any prospective direct care provider by contacting references and prior employers/agencies to elicit information regarding the reason for leaving prior employment or service; the verification shall be documented and available for review by the licensing authority;

(3) provide such other information BCU employees determine to be necessary; and

(4) maintain documentation of all applications, correspondences, and eligibility relating to the required background checks; in the event that the licensee does not have a copy of an applicant's eligibility documentation and upon receipt of a written request for a copy, the BCU may issue duplicate eligibility documentation to the original licensee provided that the request for duplicate eligibility documentation is made within one year of the applicant's eligibility date.

C. If there is a need for any further information from an applicant at any stage of the process, the BCU shall request the information in writing from the applicant. If the BCU does not receive the requested information within 15 calendar days of the date of the request, the BCU shall deny the application and send a notice of background check denial for failure to respond.

D. Any person who knowingly makes a materially false statement in connection with these requirements will be denied eligibility.

[8.8.3.10 NMAC - Rp, 8.8.3.10 NMAC, 11/20/2024]

8.8.3.11 COMPLIANCE EXCEPTIONS:

A. An applicant may not begin providing services prior to obtaining background check eligibility unless all of the following requirements are met:

(1) the licensee shall send the BCU a completed application form and an electronic fingerprint submission receipt;

(2) until receiving background eligibility, the applicant shall at all times be under direct, physical supervision; and

(3) no more than 45 days shall have passed since the date of the initial application unless the BCU documents good cause shown for an extension.

B. If a direct care provider has a break in employment or transfers employment more than 180 days after the date of an eligibility letter from the BCU, the direct care provider must re-comply with 8.8.3.10 NMAC. A direct care provider may transfer employment for a period of 180 days after the date of an eligibility letter from the BCU without complying with 8.8.3.10 NMAC only if the direct care provider submits a preliminary application that meets the following conditions:

(1) the direct care provider submits a statement swearing under penalty of perjury that they have not been arrested or charged with any crimes, have not been an alleged perpetrator of abuse or neglect, and have not been a respondent in a domestic violence petition;

(2) the direct care provider submits an application that describes the prior and subsequent places of employment and their registration or certification with sufficient detail to allow the BCU to determine if further background checks or a new application is necessary; and

(3) the BCU determines within 15 days that the direct care provider's prior background check is sufficient for the employment or position the direct care provider is going to take.

[8.8.3.11 NMAC - Rp, 8.8.3.11 NMAC, 11/20/2024]

8.8.3.12 PROHIBITIONS:

A. Any CYFD licensee who violates these rules is subject to revocation, suspension, sanctions, denial of licensure, certification, or registration; or termination of participation in any other program within the scope of these rules.

B. Licensure, certification, registration, or participation in any other program within the scope of these rules is subject to receipt by the licensing authority of a satisfactory background check for the licensee or the licensee's administrator.

C. Except as provided in 8.8.3.13 NMAC, licensure, certification, registration, or participation in any other program within the scope of these rules may not be granted by the licensing authority if a background check of the licensee or the licensee's administrator reveals an unreasonable risk.

D. A licensee may not retain employment, volunteer service or contract with any direct care provider for whom a background check reveals an unreasonable risk. The BCU shall deliver one copy of the notice of unreasonable risk to the facility or program by U.S. mail and to the licensing authority by facsimile transmission, e-mail, or hand delivery.

E. A licensee shall be in violation of these rules if it retains a direct care provider for more than ten working days following the mailing of a notice of background check denial for failure to respond by the BCU.

F. A licensee shall be in violation of these rules if it retains any direct care provider inconsistent with Subsection A of 8.8.3.11 NMAC.

G. A licensee shall be in violation of these rules if it hires, contracts with, uses in volunteer service, or retains any direct care

provider for whom information received from any source including the direct care provider, indicates the provider poses an unreasonable risk to care recipients.

H. Any firm, person, corporation, individual, or other entity that violates this section shall be subject to appropriate sanctions up to and including immediate emergency revocation of license or registration pursuant to the rules applicable to that entity or termination of participation in any other program within the scope of these rules.

[8.8.3.12 NMAC - Rp, 8.8.3.12 NMAC, 11/20/2024]

8.8.3.13 ARRESTS, CONVICTIONS AND REFERRALS:

A. For the purpose of these rules, the following information shall result in a conclusion that the applicant is an unreasonable risk:

(1) a conviction for a felony and the criminal conviction directly relates to whether the applicant can provide a safe, responsible, and morally positive setting for care recipients;

(2) a conviction, regardless of the degree of the crime or the date of the conviction, of human trafficking, criminal sexual penetration or related sexual offenses, or child abuse;

(3) a substantiated referral, regardless of the date, for sexual abuse;

(4) the applicant's child is currently in CYFD's or another state's custody; or

(5) a registration, or a requirement to be registered, on a state sex offender registry or repository or the national sex offender registry established under the Adam Walsh Child Protection and Safety Act of 2006.

B. A disqualifying conviction may be proven by:

(1) a copy of the judgment of conviction from the court;

(2) a copy of a plea agreement filed in court in which a defendant admits guilt;

(3) a copy of a report from the federal bureau of investigation, criminal information services division, or the national criminal information center, indicating a conviction;

(4) a copy of a report from the state of New Mexico, department of public safety, or any other agency of any state or the federal government indicating a conviction; or

(5) any writing about the applicant indicating that such person has been convicted of the disqualifying offense, provided; however, if that is potentially the sole basis for denial, the applicant shall be given an opportunity to show that they have successfully completed or are pending completion of a conditional discharge for the disqualifying conviction.

C. If a background check shows pending charges for a felony offense, regardless of the degree of the crime, of human trafficking, criminal sexual penetration or related sexual offenses, or child abuse; or an arrest but no disposition for any felony offense, there shall be a determination of unreasonable risk if a conviction as charged would result in a determination of unreasonable risk.

D. If a background check shows a pending child protective services referral or any other CYFD investigation of abuse or neglect, there shall be a determination of unreasonable risk.

E. If a background check shows that an applicant has an outstanding warrant, there shall be a determination of unreasonable risk.

[8.8.3.13 NMAC - Rp, 8.8.3.13 NMAC, 11/20/2024]

8.8.3.14 UNREASONABLE RISK:

A. The BCU may, in its discretion, use all reasonably reliable information about an applicant and weigh the evidence about an applicant to determine whether the applicant poses an unreasonable risk to care recipients. The BCU may also consult with the office of general counsel, treatment, assessment, or other professionals in the process of determining whether the cumulative weight of credible evidence establishes unreasonable risk.

B. In determining whether an applicant poses an unreasonable risk, the BCU need not limit its reliance on formal convictions or substantiated referrals, but nonetheless must only rely on evidence with indications of reliability such as:

(1) reliable disclosures by the applicant or a victim of abuse or neglect;

(2) orders of protection from domestic abuse (note: circumstances indicating an applicant is or has been a victim of domestic violence may be used as a mitigating factor in assessing risk);

(3) child or adult protection investigative evidence that indicates a likelihood that an applicant engaged in inappropriate conduct but there were reasons other than the credibility of the evidence to not substantiate; or

(4) any other evidence with similar indications of reliability.

[8.8.3.14 NMAC - Rp, 8.8.3.14 NMAC, 11/20/2024]

8.8.3.15 REHABILITATION PETITION: Any applicant whom the BCU concludes may be an unreasonable risk, as identified in Subsection A (1) of 8.8.3.13 NMAC, may submit to the BCU a rehabilitation petition describing with specificity all information that tends to demonstrate that the applicant is not an unreasonable risk. The petition may include a description of what actions the applicant has taken subsequent to any events revealed by the background check to reduce the risk that the same or a similar circumstance will recur. The BCU may consider the age of the applicant at conviction, time since conviction, and participation and completion in mitigating programs, treatment, and education.

[8.8.3.15 NMAC - Rp, 8.8.3.15 NMAC, 11/20/2024]

8.8.3.16 ELIGIBILITY SUSPENSIONS, REINSTATEMENTS AND REVOCATIONS:

A. An applicant's background check eligibility may be suspended for the following:

(1) an arrest or criminal charge for any felony offense, as charged would result in a determination of unreasonable risk;

(2) a pending child protective services referral or any other CYFD investigation of abuse or neglect;

(3) an outstanding warrant; or

(4) any other reason that creates an unreasonable risk determination pursuant to these rules.

B. It is the duty of the administrator of a facility or the licensee and the background check eligibility holder, upon learning of any of the above, to notify the licensing authority immediately. Failure to immediately notify the licensing authority may result in the revocation of background check eligibility.

C. A suspension of background check eligibility shall have the same effect as a determination of unreasonable risk until the matter is resolved and eligibility is affirmatively reinstated by the BCU.

D. Background check eligibility may be reinstated or revoked as follows:

(1) If the applicant can provide information relating to the disqualifying criminal charge that would show that a criminal conviction as charged would not lead to an unreasonable risk.

(2) If the matter causing the suspension is resolved within six months of the suspension, the applicant may provide documentation to the BCU showing how the matter was resolved and requesting reinstatement of background check eligibility. After review, the BCU may reinstate background check eligibility or may revoke eligibility. If, the applicant's eligibility is revoked, the applicant may appeal the revocation.

(3) If the matter causing the suspension is resolved after six months of the suspension, the applicant may reapply for clearance for the same licensee by submitting an electronic fingerprint submission receipt and the required forms. After review, the BCU may reinstate background check eligibility or may revoke eligibility. If the applicant's eligibility is revoked, the applicant may appeal the revocation.

[8.8.3.16 NMAC - Rp, 8.8.3.16 NMAC, 11/20/2024]

8.8.3.17 APPEAL RIGHTS:

A. Denials: Any applicant who is found ineligible after completion of background check may request an administrative review from the CYFD. The request for an administrative review shall be in writing and the applicant shall cause the BCU to receive it within 15 days of the date of the BCU's written notice of a determination of unreasonable risk. If the request is mailed, three days are added after the period would otherwise expire. The administrative review shall be completed by a review of the record by a hearing officer designated by the CYFD cabinet secretary. The hearing officer's review is limited to:

(1) whether the BCU's conclusion of unreasonable risk is supported by any section of these rules; and

(2) whether the applicant has been erroneously identified as a person with a relevant conviction or substantiated referral. The review will be completed on the record presented to the hearing officer and includes the applicant's written request for an administrative review and other relevant evidence provided by the applicant. The hearing officer conducts the administrative review and submits a recommendation to the cabinet secretary no later than 60 days after the date the request for administrative review is received unless CYFD and the applicant agree otherwise.

B. Suspensions and revocations: A previously cleared applicant whose eligibility has been suspended or revoked may appeal that decision to CYFD and shall be entitled to a hearing pursuant to 8.8.4 NMAC. The request for appeal shall be in writing and the applicant shall cause the BCU to receive it within 15 days of the date of the BCU's written notice of suspension. If the request is mailed, three days are added after the period would otherwise expire.

[8.8.3.17 NMAC - Rp, 8.8.3.17 NMAC, 11/20/2024]

HISTORY OF 8.8.3 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
HED 85-6 (HSD), Regulations Governing Criminal Records Check and Employment History of Licensees and Staff of Child Care Facilities, 8/30/85.

History of Repealed Material:
HED 85-6 (HSD), Regulations Governing Criminal Records Check and Employment History of Licensees and Staff of Child Care Facilities, filed - Repealed 7/30/2001.
8.8.3 NMAC, Governing Criminal Records Checks and Employment History Verification, filed 7/30/2001 - Repealed effective 3/29/2002.
8.8.3 NMAC, Governing Criminal Records Checks and Employment History Verification, filed 3/15/2002 - Repealed effective 10/30/03.
8.8.3 NMAC, Governing Background Checks and Employment History Verification, filed 10/16/2003 - Repealed effective 3/31/2006.
8.8.3 NMAC, Governing Background Checks and Employment History Verification, filed 3/31/2006 - Repealed effective 10/1/2016.
8.8.3 NMAC, Governing Background Checks and Employment History Verification, filed 10/1/2016 - Repealed effective 11/20/2024.

PUBLIC REGULATION COMMISSION

TITLE 17 PUBLIC UTILITIES AND UTILITY SERVICES
CHAPTER 9 ELECTRIC SERVICES
PART 561 CARBON DIOXIDE EMISSIONS MEASUREMENT AND COMPLIANCE

17.9.561.1 ISSUING AGENCY: New Mexico Public Regulation Commission.
[17.9.561.1 NMAC - N, 11/19/2024]

17.9.561.2 SCOPE: This rule applies to all qualifying utilities as that term is defined in the Energy Transition Act, Subsection T of Section 62-18-2 NMSA 1978, that receive approval of a financing order and issue sources of energy transition bonds.
[17.9.561.2 NMAC - N, 11/19/2024]

17.9.561.3 STATUTORY AUTHORITY: Subsection T of Section 62-18-2 NMSA 1978, Subsection D of Section 62-18-10 NMSA 1978, Paragraph (2) of Subsection B of Section 62-18-11 NMSA 1978, and Paragraph (5) of Subsection B of Section 62-19-9 NMSA 1978.
[17.9.561.3 NMAC - N, 11/19/2024]

17.9.561.4 DURATION: Permanent.
[17.9.561.4 NMAC - N, 11/19/2024]

17.9.561.5 EFFECTIVE DATE: November 19, 2024, unless a later date is cited at the end of a section.
[17.9.561.5 NMAC - N, 11/19/2024]

17.9.561.6 OBJECTIVE: The objective of this rule is to implement the requirements of, and to ensure compliance and consistency with, Subsection D of Section 62-18-10 NMSA 1978 of the Energy Transition Act.
[17.9.561.6 NMAC - N, 11/19/2024]

17.9.561.7 DEFINITIONS: Unless otherwise specified, as used in this rule:

A. Definitions beginning with "A": [RESERVED]

B. Definitions beginning with "B": [RESERVED]

C. Definitions beginning with "C":

(1) "CO2" means carbon dioxide; and

(2) "compliance period" means the triennial period over which the commission measures a qualifying utility's compliance with Subsection D of Section 62-18-10 NMSA 1978. The first compliance period is January 1, 2023 to December 31, 2025, and subsequent compliance periods follow thereafter in three-year intervals.

D. Definitions beginning with "D": [RESERVED]

E. Definitions beginning with "E": "emissions" means the production and discharge of CO2 from a qualifying utility's fleet.

F. Definitions beginning with "F": "fleet" means:

(1) the qualifying utility's generation, and

(2) the qualifying utility's sources of energy procured pursuant to power purchase agreements with terms of 24 months or longer, dedicated to serving the qualifying utility's retail customers.

G. Definitions beginning with "G": [RESERVED]

H. Definitions beginning with "H": [RESERVED]

I. Definitions beginning with "I": [RESERVED]

J. Definitions beginning with "J": [RESERVED]

K. Definitions beginning with "K": [RESERVED]

L. Definitions beginning with "L": [RESERVED]

M. Definitions beginning with "M": "MWh" means megawatt-hour(s).

N. Definitions beginning with "N": [RESERVED]

O. Definitions beginning with "O": [RESERVED]

P. Definitions beginning with "P": [RESERVED]

Q. Definitions beginning with "Q": [RESERVED]

R. Definitions beginning with "R": [RESERVED]

S. Definitions beginning with "S": [RESERVED]

T. Definitions beginning with "T": [RESERVED]

U. Definitions beginning with "U": [RESERVED]

V. Definitions beginning with "V": [RESERVED]

W. Definitions beginning with "W": [RESERVED]

X. Definitions beginning with "X": [RESERVED]

Y. Definitions beginning with "Y": [RESERVED]

Z. Definitions beginning with "Z": [RESERVED]
[17.9.561.7 NMAC - N, 11/19/2024]

17.9.561.8 CO2 EMISSIONS STANDARDS:

A. By January 1, 2023, until December 31, 2031, a qualifying utility's fleet shall not emit, on average over a compliance period, more than 400 pounds of CO2 per MWh.

B. By January 1, 2032, and for every subsequent compliance period, a qualifying utility's fleet shall not emit, on average over a compliance period, more than 200 pounds of CO2 per MWh.
[17.9.561.8 NMAC - N, 11/19/2024]

17.9.561.9 ANNUAL REPORT:

A. A qualifying utility shall file an annual report by March 15 for the preceding year's data.

B. An annual report shall include the following data:

(1) all fleet CO2 emissions;

(2) all CO2 emissions resulting from bilateral wholesale market transactions and day-ahead and real-time regional market transactions, using the most specific data available when estimated;

(3) an explanation of the qualifying utility's

progress toward compliance with Subsection D of Section 62-18-10 NMSA 1978 of the Energy Transition Act based on the current three-year compliance period;

(4) sufficient detail for the Commission to verify the calculation of the CO2 emissions and energy required to be reported;

(5) average CO2 emissions per MWh for each fleet facility greater than 10 MW;

(6) calculations pursuant to Subsection B of 17.9.561.10 NMAC with and without off-system sales included; and

(7) sufficient detail for the commission's measurement and verification of the fleet CO2 emissions rate.

C. An annual report shall include the following data for informational purposes only:

(1) all CO2 emissions and energy from sources of energy procured pursuant to power purchase agreements with terms of less than 24 months, including, but not limited to, all CO2 emissions from imported residual energy resulting from day-ahead and real-time regional market transactions;

(2) all CO2 emissions and energy associated with off-system sales, including, but not limited to, all CO2 emissions from bilateral wholesale market exports and exported residual energy resulting from real-time and day-ahead regional market transactions;

(3) forecasts of CO2 emissions and energy for the next three compliance periods; and

(4) any actions that the utility plans take to achieve compliance in subsequent years.

D. The requirements of 17.9.561.10 NMAC are separate and distinct from the procedures of 17.9.561.9 NMAC.

[17.9.561.10 NMAC - N, 11/19/2024]

17.9.561.10 COMPLIANCE, MEASUREMENT, AND VERIFICATION:

A. For each compliance period, the commission shall, upon the filing of the third annual report of the compliance period, measure and verify a qualifying utility's compliance with the CO2 emissions standards over the compliance period.

(1) Utility division staff shall evaluate the annual reports filed by the qualifying utility for the compliance period and file a recommendation for commission action within 30 days of filing of the third annual report.

(2) The qualifying utility and intervenors may file responses to staff's recommendation within 14 days.

B. In determining a qualifying utility's compliance with the CO2 emissions standards, the commission, qualifying utility, intervenors, and staff shall utilize the following formula to measure the qualifying utility's fleet CO2 emissions rate: fleet CO2 emissions rate equals total fleet CO2 emissions in pounds during the compliance period divided by total fleet energy in MWh during the compliance period.

C. The commission shall measure all energy and CO2 emissions associated with fleet on and off-system sales in the fleet CO2 emissions rate formula.

[17.9.561.9 NMAC - N, 11/19/2024]

17.9.561.11 NON-COMPLIANCE:

A. After issuing an order to show cause to a qualifying utility and making a finding of non-compliance with the CO2 emissions standards of Subsection D of Section 62-18-10 NMSA 1978 and 17.9.561.9 NMAC, the commission may impose monetary and non-monetary regulatory sanctions on the qualifying utility at the commission's discretion.

B. Before the commission imposes monetary regulatory sanctions on a qualifying utility, the qualifying utility may propose an alternative use of funds, equivalent to the amount identified by the commission to be imposed, for the purposes of advancing the objectives of this rule and the Energy Transition Act.

(1) If the commission imposes monetary regulatory sanctions or approves the qualifying utility's proposed alternative use of the funds, such amounts shall not be eligible for rate recovery.

(2) If the commission denies the qualifying utility's proposed alternative use of the funds, the commission shall require the qualifying utility to pay the monetary regulatory sanctions for remittance to the state treasurer.

[17.9.561.11 NMAC - N, 11/19/2024]

HISTORY OF 17.9.561 NMAC - [RESERVED]

PUBLIC SAFETY DEPARTMENT

This is an amendment to 10.2.4 NMAC, Sections 2, 3, 7, 8, & 9, making permanent those sections that were emergency amendments, effective 11/19/2024.

10.2.4.2 SCOPE: All law enforcement agencies eligible to receive funding from the law enforcement retention fund for the purpose of providing a retention differential disbursement to [~~eligible~~] full-time certified law enforcement officers employed by that law enforcement agency.

[10.2.4.2 NMAC - N, 4/25/2023; A/E 5/10/2024; A, 11/19/2024]

10.2.4.3 STATUTORY AUTHORITY: This rule is promulgated pursuant to Sections 9-19-6 E. and 9-19-14 NMSA 1978 of the Department of Public Safety Act, as amended by 2024 HB 193. Section 9-19-14, as amended creates a law enforcement retention fund in the state treasury and requires the Department to develop rules, forms, standards, procedures and related training for law enforcement agencies to report retention information when seeking monies to provide retention differential disbursements to eligible full-time certified law enforcement officers within the law enforcement

agency's employ.
[10.2.4.3 NMAC - N, 4/25/2023; A/E 5/10/2024; A, 11/19/2024]

10.2.4.7 DEFINITIONS: This rule adopts the definitions found in Section 9-19-2 NMSA 1978, [~~and~~] Subsection M of Section 9-19-14 NMSA 1978 and 2024 HB 193, as if fully set forth herein. In addition to the definitions adopted, the following terms have the following meaning:

A. "**Certified**" means an individual certified as a peace officer pursuant to the Law Enforcement Training Act, Section 29-7-1 to 29-7-16 NMSA 1978.

B. "**Date of hire**" means the month, date and year the individual was hired by a law enforcement agency for the purpose of serving as a full-time certified law enforcement officer with that agency.

[~~**B.**~~] **C.** "**DPS**" means the department of public safety.

[~~**C.**~~] **D.** "Eligible law enforcement agency" means an agency eligible to receive monies from the LERF because the agency:

(1) has, prior to June 1 of the reporting fiscal year, made a request for monies from the DPS and included in that request the information on which the agency is required to report under Section 9-19-14 H NMSA 1978 and this rule;

(2) is, at the time of submitting the request for monies to DPS in compliance with that portion of the Law Enforcement Training Act that requires every law enforcement agency to submit a quarterly report to the director of the law enforcement academy and the New Mexico law enforcement standards and training council; and

(3) has, at the time of submitting the request for monies to DPS, submitted the agency's most current roster of full-time certified law enforcement officers, including commission dates, to the New Mexico law enforcement academy.

E. "**Eligible officer**" means [~~an officer who has remained employed as a law enforcement officer with the same law enforcement agency one year and one day after reaching four, nine, fourteen and nineteen years of consecutive service from the law enforcement officer's date of hire with that law enforcement agency~~] a full-time certified law enforcement officer employed by any law enforcement agency, who after completing four, nine, 14, 19, or 20 or more years of service since the law enforcement officer's initial date of hire, remains employed for one additional year with the law enforcement agency by whom the officer was employed at the time the officer completed four, nine, 14, 19 or 20 or more years of service and who is in compliance with the in-service training and reporting requirements of the Law Enforcement Training Act.

[~~**D.**~~] **F.** "**Employer tax liability**" means the employer contribution for payroll taxes outlined in the Federal Insurance Contribution Act for Social Security and/or Medicare. This does not include any employer contributions for retirement or other benefit plans.

[~~**E.**~~] **G.** "**Law enforcement academy**" means the New Mexico law enforcement academy created by Section 29-7-2 NMSA 1978 or any of the satellite academies certified by the New Mexico law enforcement [~~academy board~~] standards and training council, its predecessors, or successors.

[~~**F.**~~] **H.** "**Law enforcement retention fund**" means a fund in the state treasury, consisting of money appropriated by the legislature, federal money granted to the state for the purposes of the fund, income from investment of the fund and money otherwise accruing to the fund. Money in the fund does not revert to any other fund at the end of the fiscal year. The fund is administered by DPS to provide monies to law enforcement agencies who request the funds for the purpose of providing retention differential disbursements to full-time certified law enforcement officers within the agency's employ who meet [~~statutorily prescribed~~] requirements prescribed by statute and by this rule.

[~~**G.**~~] **I.** "**LERF**" means law enforcement retention fund.

[~~**H.**~~] **J.** "**Portal**" means the electronic system through which law enforcement agencies annually report to the DPS the data required by this rule in order [~~for the law enforcement agency~~] to receive funding from the law enforcement retention fund for the purpose of providing retention differential disbursements to eligible officers employed by that agency.

[~~**I.**~~] **K.** "**PRDD**" means the amount of the projected retention differential disbursement stated in dollars and cents to be paid to the eligible officer.

[~~**J.**~~] **L.** "**Reporting fiscal year**" means the fiscal year in which the law enforcement agency is reporting to DPS the information set forth in Subsection A of 10.2.4.9 NMAC.

[~~**K.**~~] **M.** "**Salary**" means the base hourly rate of pay of the full-time certified law enforcement officer for two thousand eighty hours, excluding overtime, any percentage pay increases or multiple components of pay.

[~~**L.**~~] **N.** "**Years of service**" means the number of [~~consecutive~~] years, months and days, beginning with the date of hire, a full-time certified law enforcement officer is employed by a law enforcement agency for the purpose of serving as a full-time certified law enforcement officer with a [~~single~~] law enforcement agency.
[10.2.4.7 NMAC - N, 4/25/2023 ; A/E 5/10/2024; A, 11/19/2024]

10.2.4.8 CALCULATION OF THE PROJECTED FIVE PERCENT RETENTION DIFFERENTIAL DISBURSEMENT BY THE REPORTING LAW ENFORCEMENT AGENCY: The salary used by the law enforcement agency to calculate the five percent retention differential disbursement for those officers projected to be eligible officers in the upcoming fiscal year, shall be the salary of the officer on the date the officer reached four, nine, 14, [~~or~~] 19 or 20 or more years of [~~consecutive~~] service with the law enforcement agency requesting the

retention differential disbursement. [10.2.4.8 NMAC - N, 4/25/2023; A/E 5/10/2024; A, 11/19/2024]

10.2.4.9 REPORTING REQUIREMENTS FOR AGENCIES SEEKING RETENTION DIFFERENTIAL DISBURSEMENTS

A. Every law enforcement agency seeking monies from the LERF for retention differential disbursements for full-time certified law enforcement officers within its employ, who are projected to be eligible officers in the upcoming fiscal year, shall annually report to DPS the following information:

(1) The full legal name and date of hire of the full-time certified law enforcement officer projected to be an eligible officer in the upcoming fiscal year, the PRDD for [~~that~~] each officer, the amount of the annual salary on which the PRDD was calculated and the amount of the employer tax liability attributable to the PRDD. The amount of the employer tax liability shall specify the amount attributable to Social Security and the amount attributable to Medicare;

(2) The aggregate number of full-time certified law enforcement officers employed by the law enforcement agency during each of the five fiscal years immediately preceding the reporting fiscal year. For any officer employed less than a full fiscal year, the law enforcement agency shall report the number of months and days the officer was employed, identifying the officer without personally identifying information (e.g. Officer # 1, Officer # 2, etc.).

(3) For each officer included in Paragraph (2) of Subsection A above, the number of years (or partial years) of service of each full-time certified law enforcement officer with the reporting agency.

(4) The number of full-time certified law enforcement officers that left the employ of the law enforcement agency during the fiscal year immediately preceding the reporting fiscal year. The number of years of service with the reporting law enforcement agency of each departing officer [~~and~~], the [~~stated reasons why each law enforcement officer left the employ of the law enforcement agency~~] agency's reason for each involuntary departure and the officer's stated reason, if any, for each voluntary departure.

(5) The number of applicants to the full-time certified law enforcement agency for a position as a law enforcement officer during the fiscal year immediately preceding the reporting fiscal year.

(6) The number of applicants to the law enforcement agency for a position as a full-time certified law enforcement officer in the fiscal year immediately preceding the reporting fiscal year, who attended a law enforcement academy.

(7) The number of full-time certified law enforcement officers within the reporting agency's employ who received one or more certifications during the fiscal year immediately preceding the reporting fiscal year.

(8) The number of full-time certified law enforcement officers added to the law enforcement agency by way of lateral transfer during the fiscal year immediately preceding the reporting fiscal year and the years of service of each added officer at each previous law enforcement agency if known to the reporting agency.

(9) Any changes to compensation, recruiting, retention or benefits of full-time certified law enforcement officers implemented by the law enforcement agency during the fiscal year immediately preceding the reporting fiscal year.

(10) The number of full-time certified law enforcement officers that are projected to become eligible for a retention differential disbursement in the upcoming fiscal year, and the projected amount of the retention differential disbursement including any employer tax liabilities for each eligible officer.

(11) Any other information requested by DPS that is used for determining retention rates, unless disclosure of such information is otherwise prohibited by law.

B. The information in Subsection A above shall be reported to the DPS for the upcoming fiscal year no later than May 31.

C. The information in Subsection A above shall be reported to the DPS through the electronic portal, unless DPS advises the applying law enforcement agencies that a different reporting method should be used.

D. In order to receive funding for retention differential disbursements, the law enforcement agency must, at the time of the request, be in compliance with the in-service officer training and reporting requirements of the New Mexico Law Enforcement Training Act set forth in Section 29-7-7.1 NMSA 1978 and 29-7-7.2 NMSA 1978.

E. In order to receive funding for retention differential disbursements, the law enforcement agency must have submitted the agency's most current roster of full-time certified law enforcement officers, including commission dates, to the New Mexico law enforcement academy no later than April 1 of the reporting fiscal year.

[10.2.4.9 NMAC - N, 4/25/2023; A/E 5/10/2024; A, 11/19/2024]

REGULATION AND LICENSING DEPARTMENT

CONSTRUCTION INDUSTRIES DIVISION

This is an amendment to 14.12.9 NMAC, Section 13, effective 01/01/2025.

14.12.9.13 INSTALLATION INSPECTIONS:

A. The division shall inspect each installation of a manufactured home.

B. The division shall issue a notice of violation to the licensee responsible for the violation whenever a manufactured home contains a violation of the installation requirements pursuant to regulations. The notice shall include a description of each violation.

C. Upon correction of any violation the licensee responsible for the correction of the violation shall pay the re-inspection fee and request a re-inspection of the manufactured home [~~shall be requested~~].

D. Upon receipt of an inspection request, the division shall inspect the manufactured home and shall post notice of any continuing violation.

[~~**E.** Mechanical, electrical and general construction contractors licensed with the construction industries division and who perform work on manufactured homes are not required to hold a license with the manufactured housing division. However, they must be registered with the manufactured housing division. The registration form shall show the name of the license holder, business address, mailing address, type of license issued by the construction industries division, expiration date of license, and the name of the qualifying party. Registrants must pay any required fee and must post a consumer protection bond with the division.~~

~~**F.**~~] **E.** All materials used in the installation of all manufactured homes shall be listed materials or have prior written approval of the division.

[14.12.9.13 NMAC - Rp, 14.12.2.40 NMAC, 12/01/2010; A, 01/01/2025]

SUPERINTENDENT OF INSURANCE, OFFICE OF

This is an amendment to 13.2.2 NMAC, Sections 1, 2, 7, 13, 22, adding a new 23, and renumbering 24, effective 11/19/2024.

13.2.2.1 ISSUING AGENCY: New Mexico Office of Superintendent of Insurance [~~("OSI")~~].

[13.18.3.1 NMAC – Rp, 13.18.3.1 NMAC, 7/24/2018; A, 10/01/2020]

13.2.2.2 SCOPE: This rule applies to all insurers and affiliates subject to [~~the~~] Chapter 59A, Article 37, NMSA 1978, [~~("the Insurance Holding Company Law")~~] (the Insurance Holding Company Law).

[13.2.2.2 NMAC – Rp, 13.2.2.2 NMAC, 7/24/2018; A, 10/01/2020; A, 11/19/2024]

13.2.2.7 DEFINITIONS: The following terms have the meaning given, unless the context otherwise requires. Other terms used in this rule have the meanings given in the Insurance Holding Company Law or in Chapter 59A, NMSA 1978, [~~("the Insurance Code.")~~].hereafter the Insurance Code.

A. "Executive officer" means chief executive officer, chief operating officer, chief financial officer, treasurer, secretary, controller and any other individual performing functions corresponding to those performed by such officers under whatever title.

B. "Group-wide supervisor"means the regulatory official authorized to engage in conducting and coordinating group-wide supervision activities who is determined or acknowledged by the superintendent under Section 13.2.2.23 NMAC to have [~~sufficeient signaificant~~] sufficient significant contacts with the internationally active insurance group.

C. "Internationally active insurance group" means an insurance holding company system that [~~1)~~] includes an insurer registered under Section 59A-37-11 NMSA 1978 and [~~2)~~] meets the following criteria:

(1) premiums written in at least three countries;

(2) the percentage of gross premiums written outside the United States is at least ten percent of the insurance holding company system's total gross written premiums; and

(3) based on a three-year rolling average, the total assests of the insurance holding company system are at least $50,000,000,000 or the total gross written premiums of the insurance holding company system are at least $10,000,000,000.

D. "NAIC" means the national association of insurance commissioners.

E. "OSI" means the office of superintendent of insurance.

F. "Receivership act" means the Receivership Act, Sections 44-8-1 through 44-8-10 NMSA 1978.

[~~**F.**~~] **G. "SEC"** means the United States securities and exchange commission.

[~~**G.**~~] **H. "Superintendent"** means the superintendent of insurance, the office of superintendent of insurance or employees of the office of superintendent of insurance acting within the scope of the superintendent's official duties and with the superintendent's authorization. [~~and~~]

[~~**H**~~] **I.** [~~**ultimate**~~] **"Ultimate controlling person"** means a person that is not controlled by any other person.

[13.2.2.7 NMAC – Rp, 13.2.2.7 NMAC, 7/24/2018; A, 10/01/2020; A, 11/19/2024]

13.2.2.13 FORM B:

A. When required: An insurer required by Section 59A-37-11 NMSA 1978 to file an annual registration statement shall file Form B in accordance with the requirements of this rule.

B. Filings on behalf of affiliates: Any authorized insurer may file a registration statement on behalf of any affiliated insurer or insurers that are required to register under Section 59A-37-11 NMSA 1978.

C. Additional information permitted: A registration statement may include information not required by this rule regarding any insurer in the insurance holding company system even if the insurer is not authorized to do business in this state.

D. When copy of domiciliary registration permitted: In lieu of filing a registration statement on Form B, the authorized insurer may file a copy of the registration statement or similar report that it is required to file in its state of domicile, provided:

(1) the statement or report contains substantially similar information required to be furnished on Form B; and

(2) the filing insurer is the principal insurance company in the insurance holding company system. The question of whether the filing insurer is the principal insurance company in the insurance holding company system is a question of fact and an insurer filing a registration statement or report in lieu of Form B on behalf of an affiliated insurer, shall set forth a brief statement of facts which will substantiate the filing insurer's claim that it, in fact, is the principal insurer in the insurance holding company system.

E. Filings by unauthorized insurers: With the prior approval of the superintendent, an unauthorized insurer may follow any of the procedures that could be done by an authorized insurer under Subsections B, C and D of 13.2.2.13 NMAC.

F. Consolidated filings and alternative registration: Any insurer may take advantage of the provisions of Sections 59A-37-16 and 17 NMSA 1978 without obtaining the prior approval of the superintendent. The superintendent, however, reserves the right to require individual filings if the superintendent deems such filings necessary in the interest of clarity, ease of administration or the public good.

G. Information to be furnished in Form B:

(1) Caption: Place the following caption at the top of the cover page:

FORM B
INSURANCE HOLDING COMPANY ANNUAL REGISTRATION STATEMENT FILED WITH THE NEW MEXICO OFFICE OF SUPERINTENDENT OF INSURANCE

(2) Registrant: State the name of the registrant filing the statement.

(3) Other registrants: State the name and address of each insurance company on whose behalf the statement is being filed.

(4) Date: Provide the filing date of the statement.

(5) Designation of agent: State the name, title, address and telephone number of the individual to whom notices and correspondence concerning this statement should be addressed.

(6) Identity and control of registrant: Furnish the exact name of each insurer registering or being registered, the home office address and principal executive offices of each; the date on which each registrant became part of the insurance holding company system; and the method(s) by which control of each registrant was acquired and is maintained.

(7) Organizational chart: Furnish a chart or listing clearly presenting the identities of and interrelationships among all affiliated persons within the insurance holding company system. The chart or listing should show the percentage of each class of voting securities of each affiliate that is owned, directly or indirectly, by another affiliate. If control of any person within the system is maintained other than by the ownership or control of voting securities, indicate the basis of control. As to each person specified in the chart or listing, indicate the type of organization (e.g., corporation, trust, partnership) and the state or other jurisdiction of domicile.

(8) The ultimate controlling person: Provide the following information about the ultimate controlling person in the insurance holding company system:

(a) name;

(b) home office address;

(c) principal executive office address;

(d) the organizational structure of the person, i.e., corporation, partnership, individual, trust, etc.;

(e) the principal business of the person;

(f) the name and address of any person who holds or owns ten percent or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned; and

(g) if court proceedings involving a reorganization or liquidation are pending, indicate the title and location of the court, the nature of the proceedings and the date when commenced.

(9) Biographical information: Furnish the following information for the directors and executive officers of the ultimate controlling person: the individual's name and address, the individual's principal occupation and all offices and positions held during the past five years, and any conviction for crimes other than minor traffic violations.

(10) Transactions and agreements: Briefly describe the following agreements in force, and transactions currently outstanding or that have occurred during the last calendar year between the registrant and its affiliates in such a manner as to permit the proper evaluation of the transaction by the superintendent. Include at least the following information with respect to each: the nature and purpose of the transaction, the nature and amounts of any payments or transfers of assets between the parties, the identity of all parties to the transaction, and the relationship of the affiliated parties to the registrant. No information need be disclosed if such information is not

material for purposes of Section 59A-37-11 NMSA 1978. Sales, purchases, exchanges, loans or extensions of credit, investments or guarantees involving one-half of one percent or less of the registrant's admitted assets as of the 31st day of December next preceding shall be deemed not material.

(a) loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the registrant or of the registrant by its affiliates;

(b) purchases, sales or exchanges of assets;

(c) transactions not in the ordinary course of business;

(d) guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the registrant's assets to liability, other than insurance contracts entered into in the ordinary course of the registrant's business;

(e) all management agreements, service contracts and all cost-sharing arrangements;

(f) reinsurance agreements;

(g) dividends and other distributions to shareholders;

(h) consolidated tax allocation agreements; and

(i) any pledge of the registrant's stock and/or of the stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

(11) Litigation or administrative proceedings: Provide a brief description of any litigation or administrative proceedings of the following types, either then pending or concluded within the preceding fiscal year, to which the ultimate controlling person or any of its directors or executive officers was a party or of which the property of any such person is or was the subject; give the names of the parties and the court or agency in which the litigation or proceeding is or was pending:

(a) criminal prosecutions or administrative proceedings by any government agency or authority that may be relevant to the trustworthiness of any party to the proceedings; and

(b) proceedings that may have a material effect upon the solvency or capital structure of the ultimate holding company including, but not necessarily limited to, bankruptcy, receivership or other corporate reorganization.

(12) Statement regarding plan or series of transactions: The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions, the purpose of which is to avoid statutory threshold amounts and the review that might otherwise occur.

(13) Financial statements and exhibits:

(a) List under this item the financial statements and exhibits to be attached to this statement as appendices.

(b) If the ultimate controlling person is a corporation, an organization, a limited liability company, or [~~ther~~] other legal entity, the financial statements shall include the annual financial statements of the ultimate controlling person in the insurance holding company system as of the end of the person's latest fiscal year. If at the time of the initial registration, the annual financial statements for the latest fiscal year are not available, annual statements for the previous fiscal year may be filed and similar financial information shall be filed for any subsequent period to the extent such information is available. Such financial statements may be prepared on either an individual basis; or, unless the superintendent otherwise requires, on a consolidated basis if consolidated statements are prepared in the usual course of business.

(c) Other than with respect to the foregoing, such financial statements shall be filed in a standard form and format adopted by the NAIC, unless an alternative form is accepted by the superintendent. Documentation and financial statements filed with the SEC or audited GAAP financial statements shall be deemed to be an appropriate form and format.

(d) Unless the superintendent otherwise permits, the annual financial statements shall be accompanied by the certificate of an independent public accountant to the effect that the statements present fairly the financial position of the ultimate controlling person and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the ultimate controlling person is an insurer which is actively engaged in the business of insurance, the annual financial statements need not be certified, provided they are based on the annual statement of the insurer filed with the insurance department of the insurer's domiciliary state and are in accordance with requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of that state.

(e) Any ultimate controlling person who is an individual may file personal financial statements that are reviewed rather than audited by an independent public accountant. The review shall be conducted in accordance with the standards for review of personal financial statements published in the *Personal Financial Statements Guide* by the American Institute of Certified Public Accountants. Personal financial statements shall be accompanied by the independent public accountant's Standard Review Report stating that the accountant is not aware of any material modifications that should be made to the financial statements in order for

the statements to be in conformity with generally accepted accounting practices.

(f) Exhibits shall include copies of the latest annual reports to shareholders of the ultimate controlling person and proxy material used by the ultimate controlling person; and any additional documents or papers required by Form B or 13.2.2.10 NMAC.

(14) Signature and certification: The following signature and certification are required at the end of Form B.

Pursuant to the requirements of Section 59A-37-12 NMSA 1978, registrant has caused this annual registration statement to be duly signed on its behalf in the city of [insert name of city] and state of New Mexico on [insert date].

(SEAL)

BY:_____

_____

(Title)

_____

(Name of Applicant)

Attest:

_____

(Signature of Officer)

_____

(Title)

The undersigned deposes and says that they have duly executed the attached annual registration statement dated [insert date], for and on behalf of [insert name of registrant]; that they are the [insert title of deponent] of such company and that they are authorized to execute and file this instrument. Deponent further says that they are familiar with the instrument and its contents, and that the facts set forth in the instrument are true to the best of their knowledge, information and belief.

_____

(Signature of deponent)

_____

(Typed name and title of deponent)

[13.2.2.13 NMAC – Rp, 13.2.2.13 NMAC, 7/24/2018; A, 10/01/2020; A, 11/19/2024]

13.2.2.22 GROUP-WIDE SUPERVISION OF INTERNATIONALLY ACTIVE INSURANCE GROUPS:

A. The superintendent may act as the group-wide supervisor for any internationally active insurance group in accordance with the provisions of this section. However, the superintendent may otherwise acknowledge another regulatory official as the group-wide supervisor where the internationally active insurance group:

(1) Does not have substantial insurance operations in the United States;

(2) Has substantial insurance operations in the United States, but not in this state; or

(3) Has substantial insurance operations in the United States and this state, but the superintendent has determined pursuant to the factors set forth in Subsections B and F of this section that the other regulatory official is the appropriate group-wide supervisor. An insurance holding company system that does not otherwise qualify as an internationally active insurance group may request that the superintendent make a determination or acknowledgment as to a group-wide supervisor pursuant to this section.

B. In cooperation with other state, federal and international regulatory agencies, the superintendent will identify a single group-wide supervisor for an internationally active insurance group. The superintendent may determine that the superintendent is the appropriate group-wide supervisor for an internationally active insurance group that conducts substantial insurance operations concentrated in this state. However, the superintendent may acknowledge that a regulatory official from another jurisdiction is the appropriate group-wide supervisor for the internationally active insurance group. The superintendent shall consider the following factors when making a determination or acknowledgment under this subsection:

(1) The place of domicile of the insurers within the internationally active insurance group that holds the largest share of the group's written premiums, assets or liabilities;

(2) The place of domicile of the top-tiered insurer(s) in the insurance holding company system of the internationally active insurance group;

(3) The location of the executive offices or largest operational offices of the internationally active insurance group;

(4) Whether another regulatory official is acting or is seeking to act as the group-wide supervisor under a regulatory system that the superintendent determines to be:

(a) Substantially similar to the system of regulation provided under the laws of this state, or

(b) Otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials; and

(5) Whether another regulatory official acting or seeking to act as the group-wide supervisor provides the superintendent with reasonably reciprocal recognition and cooperation.

(6) However, a regulatory official identified in this section as the group-wide supervisor may determine that it is appropriate to [~~acknowlege~~] acknowledge another supervisor to serve as the group-wide supervisor. Acknowledgement of the group-wide supervisor shall be made after consideration of the factors listed in Paragraph (1) through (5) above, and shall be made in cooperation with and subject to the acknowledgement of other regulatory officials involved with supervision of a member of the internationally active insurance group, and in consultation with the internationally active insurance group.

C. Notwithstanding any other provisions of law, when another regulatory official is acting as the group-wide supervisor of an internationally active insurance group, the superintendent shall acknowledge that regulatory official as the group-wide supervisor. However, in the

event of material change in the internationally active insurance group that results in either:

(1) The internationally active insurance group's insurers domiciled in this state holding the largest share of the group's premiums, assets or liabilities; or

(2) This state being the place of domicile of the top-tiered insurer(s) in the insurance holding company system of the internationally active insurance group, then the superintendent shall make a determination or acknowledgement as to the appropriate group-wide supervisor for such internationally active insurance group pursuant to Subsection B of this section.

D. Pursuant to Section 59A-37-23 NMSA 1978, the superintendent is authorized to collect from any insurer registered pursuant to Section 59A-37-11 NMSA 1978, all information necessary to determine whether the superintendent may act as the group-wide supervisor of an internationally active insurance group or if the superintendent may acknowledge another regulatory official to act as the group-wide supervisor. Prior to issuing a determination that an internationally active insurance group is subject to group-wide supervision by the superintendent, the superintendent will notify the insurer registered pursuant to Section 59A-37-11 NMSA 1978, and the ultimate controlling person within the internationally active insurance group. The internationally active insurance group shall have not less than 30 days to provide the superintendent with additional information pertinent to the pending determination. The OSI will publish on its website the identity of internationally active insurance groups that the superintendent has determined are subject to group-wide supervision by the superintendent.

E. If the superintendent is the group-wide supervisor for an internationally active insurance group, the superintendent is authorized to engage in any of the following group-wide supervision activities:

(1) Assess the enterprise risk within the internationally active insurance group to ensure that:

(a) The material financial condition and liquidity risks to the members of the internationally active insurance group that are engaged in the business of insurance are identified by management, and

(b) Reasonable and effective mitigation measures are in place;

(2) Request from any member of an internationally active insurance group subject to the superintendent's supervision, information necessary and appropriate to assess enterprise risk, including, but not limited to, information about the members of the internationally active insurance group regarding:

(a) Governance, risk assessment and management,

(b) Capital adequacy, and

(c) Material intercompany transactions;

(3) Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to timely recognize and mitigate enterprise risks to members of such internationally active insurance group that are engaged in the business of insurance;

(4) Communicate with other state, federal and international regulatory agencies for members within the internationally active insurance group and share relevant information subject to the confidentiality provisions of Section 59A-37-24 NMSA 1978, through supervisory colleges as provided in this rule or otherwise;

(5) Enter into agreements with or obtain documentation from any insurer registered under Section 59A-37-11 NMSA 1978, any member of the internationally active insurance group, and any other state, federal and international regulatory agencies for members of the internationally active insurance group, providing the basis for or otherwise clarifying the superintendent's role as group-wide supervisor, including provisions for resolving disputes with other regulatory officials. Such agreements or documentation shall not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not domiciled or incorporated in this state is doing business in this state or is otherwise subject to jurisdiction in this state; and

(6) Other group-wide supervision activities, consistent with the authorities and purposes enumerated above, as considered necessary by the superintendent.

F. If the superintendent acknowledges that another regulatory official from a jurisdiction that is not accredited by the NAIC is the group-wide supervisor, the superintendent may reasonably cooperate, through supervisory colleges or otherwise, with group-wide supervision undertaken by the group-wide supervisor, provided that:

(1) The superintendent's cooperation is in compliance with the laws of this state; and

(2) The regulatory official acknowledged as the group-wide supervisor also recognizes and cooperates with the superintendent's activities as a group-wide supervisor for other internationally active insurance groups where applicable. Where such recognition and cooperation is not reasonably reciprocal, the superintendent is authorized to refuse recognition and cooperation.

G. The superintendent may enter into agreements with or obtain documentation from any insurer registered under Section 59A-37-11 NMSA 1978, any affiliate of the insurer, and other state, federal

and international regulatory agencies for members of the internationally active insurance group, that provide the basis for or otherwise clarify a regulatory official's role as group-wide supervisor.

H. A registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the superintendent's participation in the administration of this section, including the engagement of attorneys, actuaries and any other professionals and all reasonable travel expenses.

I. All information, data, reports and workpapers filed with and collected by the superintendent pursuant to this section will be obtained in accordance with Section 59A-4-5 NMSA 1978 and subject to the confidentiality provisions of Section 59A-4-11 and 59A-37-24, NMSA 1978, and the stricter of these provisions shall apply. [13.2.2.22 NMAC – N, 10/01/2020; A, 11/19/2024]

13.2.2.23 TRANSACTIONS SUBJECT TO PRIOR NOTICE – NOTICE FILING:

A. An insurer required to give notice of a proposed transaction pursuant to 13.2.2.11 NMAC, shall furnish the required information on Form D, hereby made a part of these regulations.

B. Agreements for cost sharing services and management services shall at a minimum and as applicable:

(1) Identify the person providing services and the nature of such services;

(2) set forth the methods to allocate costs;

(3) require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the accounting practices and procedures manual;

(4) prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement;

(5) state that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance;

(6) define records and data of the insurer to include all records and data developed or maintained under or related to the agreement that are otherwise the property of the insurer, in whatever form maintained, including, but not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records or similar records within the possession, custody or control of the affiliate;

(7) specify that all records and data of the insurer are and remain the property of the insurer, and:

(a) are subject to control of the insurer;

(b) are identifiable; and

(c) are segregated from all other persons' records and data or are readily capable of segregation at no additional cost to the insurer;

(8) state that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer and are subject to the control of the insurer;

(9) include standards for termination of the agreement with and without cause;

(10) include provisions for indemnification of the insurer in the event of gross negligence or willful misconduct on the part of the affiliate providing the services and for any actions by the affiliate that violate provisions of the agreement required in Paragraphs (11) through (15) of Subsection B of this section;

(11) specify that if the insurer is placed in supervision, seizure, conservatorship or receivership pursuant to the receivership act:

(a) all of the rights of the insurer under the agreement extend to the receiver or to the extent permitted by New Mexico law;

(b) all records and data of the insurer shall be identifiable and segregated from all other persons' records and data or readily capable of segregation at no additional cost to the receiver or the superintendent;

(c) a complete set of records and data of the insurer will immediately be made available to the receiver or the superintendent, shall be made available in a usable format and shall be turned over to the receiver or superintendent immediately upon the receiver or the superintendent's request, and the cost to transfer data to the receiver or the superintendent shall be fair and reasonable; and

(d) the affiliated person(s) will make available all employees essential to the operations of the insurer and the services associated therewith for the immediate continued performance of the essential services ordered or directed by the receiver or superintendent;

(12) specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to the receivership act;

(13) specify that the affiliate will provide the essential services for a minimum period of time (specified in the agreement) after termination of the agreement, if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to the receivership act, as ordered or directed by the receiver or superintendent. Performance of the essential services will continue to be provided without regard to pre-receivership unpaid fees, so long as the affiliate continues to receive timely payment for post-receivership services rendered, and unless released by the receiver, superintendent or supervising court;

(14) specify that the affiliate will continue to maintain any systems, programs or

other infrastructure, notwithstanding supervision, seizure, conservatorship or receivership pursuant to the receivership act, and will make them available to the receiver or superintendent as ordered or directed by the receiver or superintendent for so long as the affiliate continues to receive timely payment for post-receivership services rendered, and unless released by the receiver, superintendent or supervising court; and

(15) specify that, in furtherance of the cooperation between the receiver and the affected guaranty association(s) and subject to the receiver's authority over the insurer, if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to the receivership act, and portions of the insurer's policies or contracts are eligible for coverage by one or more guaranty associations, the affiliate's commitments under Paragraphs (11) through (15), of Subsection B of this section will extend to such guaranty association(s).

[13.2.2.23 NMAC – N, 11/19/2024]

[~~13.2.2.23~~] 13.2.2.24 SEVERABILITY CLAUSE: If any provision of this rule or the application thereof to any person or circumstance, is held invalid, such determination shall not affect other provisions or applications of this rule which can be given effect without the invalid provision or application, and to that end, the provisions of this rule are severable.

[13.2.2.24 NMAC – Rn & A, 13.2.2.21 NMAC, 10/01/2020; Rn, 13.2.2.23 NMAC, 11/19/2024]

History of 13.2.2 NMAC: [RESERVED]

SUPERINTENDENT OF INSURANCE, OFFICE OF

This is an amendment to 13.10.17 NMAC, sections 1, 2, 3, 7, 9, 10, 15, 17, 18, 19, 21, 22, 23, 24, 31 and 33 effective 11/19/2024.

13.10.17.1 ISSUING AGENCY: Office of Superintendent of Insurance [~~(OSI), Managed Health Care Bureau (MHCB).~~]

[13.10.17.1 NMAC - Rp, 13.10.17.1 NMAC, 1/1/2017; A, 11/19/2024]

13.10.17.2 SCOPE:

A. Applicability. This rule applies to all health care insurers that provide, offer or administer health benefits plans, including health benefits plans:

(1) with a point-of-service option that allows subscribers to obtain health care services out-of-network;

(2) provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act (Sections 13-7-1 through 13-7-11 NMSA 1978); and

(3) utilizing a preferred provider network, as defined under Section 59A-22A-3 NMSA 1978.

B. Exemptions. This rule does not apply to policies or certificates that provide coverage for:

(1) only short-term travel, accident-only, specified disease or other limited benefits; or

(2) credit, disability income, hospital indemnity, long-term care insurance, limited scope vision care, limited scope dental or any other limited supplemental benefit; or

(3) self-funded plans that are subject to the Employee Retirement Income Security Act of 1974 (ERISA).

C. Conflicts. For purpose of this rule, if any provision in this rule conflicts with any provision in 13.10.13 NMAC, Managed Health Care or 13.10.16 NMAC, Provider Grievances, the provisions in this rule shall apply.

[13.10.17.2 NMAC - Rp, 13.10.17.2 NMAC, 1/1/2017; A, 11/19/2024]

13.10.17.3 STATUTORY AUTHORITY: Sections 59A-1-16, 59A-2-8, 59A-2-9, 59A-15-16, 59A-16-3, 59A-16-11, 59A-16-12, 59A-16-12.1, 59A-16-20, 59A-16-22, 59A-19-4, 59A-19-6, 59A-22A-7, 59A-46-10, 59A-46-11, [~~59A-57-2, 59A-57-4, and 59A-57-5 NMSA 1978~~] 59A-57-1 through 59A-57-11 NMSA 1978.

[13.10.17.3 NMAC - Rp, 13.10.17.3 NMAC, 1/1/2017; A, 11/19/2024]

13.10.17.7 DEFINITIONS: As used in this rule:

A. "Administrative decision" means a decision made by a health care insurer regarding any aspect of a health benefits plan other than an adverse determination, including but not limited to:

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

(2) claims payment, handling or reimbursement for health care services, including but not limited to complaints concerning co-payments, co-insurance and deductibles; and

(3) terminations of coverage.

B. "Administrative grievance" means an oral or written complaint submitted by or on behalf of a covered person regarding an administrative decision.

C. "Adverse determination" means any of the following:

(1) any rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time);

(2) a denial, reduction, or termination of, or a failure to make full or partial payment for a benefit including any such denial, reduction, termination, or failure to make payments, that is based on a determination of a covered person's eligibility to participate in a health benefits plan; or

(3) a denial, reduction or termination of, or a failure to make full or partial payment for a benefit resulting from the application of any utilization review; or

(4) failure to cover an item or service for which

benefits are otherwise provided because it is determined to be experimental, or investigational or not medically necessary or appropriate.

D. "Adverse determination grievance" means an oral or written complaint submitted by or on behalf of a covered person regarding an adverse determination.

E. "Certification" means a determination by a health care insurer that a health care service requested by a provider or covered person has been reviewed and, based upon the information available, meets the health care insurer's requirements for determining medical necessity, appropriateness, health care setting, level of care and effectiveness, and the requested health care service is therefore approved.

F. "Clinical peer" means a physician or other health care professional who holds a non-restricted license in a state in the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

G. "Co-insurance" is a cost-sharing plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid; co-insurance rates may differ for different types of services.

H. "Co-payment" is a cost-sharing plan that requires an insured person to pay a fixed dollar amount when a medical service is received or when purchasing medicine after the deductible amount, with the health care insurer paying the balance; there may be different co-payments for different types of service.

I. "Covered benefits" means those health care services to which a covered person is entitled under the terms of a health benefits plan.

J. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

K. "Culturally and linguistically appropriate manner of notice" means:

(1) Notice that meets the following requirements:

(a) the health care insurer must provide oral language services (such as the telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and reviews (including IRO reviews and external reviews) in any applicable non-English language;

(b) the health care insurer must provide, upon request, a notice in any applicable non-English language; and

(c) the health care insurer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the health care insurer.

(2) For purposes of this definition, with respect to an address in any New Mexico county to which a notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined by the department of health human services (HHS); the counties that meet this ten percent standard, as determined by HHS, are found at http://cciio.cms.gov/resources/factsheets/clas-data.html and any necessary changes to this list are posted by HHS annually.

L. "Day or Days" shall be interpreted as follows, unless otherwise specified:

(1) [~~1-5~~] one to five days means only working days and excludes weekends and state holidays; and

(2) [~~6~~] six days or more means calendar days, including weekends and holidays.

M. "Deductible" means a fixed dollar amount that the covered person may be required to pay during the benefit period before the health care insurer begins payment for covered benefits; plans may have both individual and family deductibles and separate deductibles for specific services.

N. "Expedited review" means a review with a shortened timeline, as described in sections 13.10.17.14 NMAC, 13.10.17.16 NMAC, 13.10.17.21 NMAC, 13.10.17.22 NMAC, and 13.10.17.24 NMAC, which is required in urgent care situations or when the grievant is receiving an on-going course of treatment which the health care insurer seeks to reduce or terminate.

O. "External review" means the external review conducted pursuant to this rule by the superintendent or by an IRO appointed by the superintendent, depending on the circumstances.

P. "Final adverse determination" means an adverse determination that has been upheld by a health care insurer at the conclusion of the internal review process.

Q. "Grievance" means an oral or written complaint submitted by or on behalf of a covered person regarding either an adverse determination or an administrative decision.

R. "Grievant" means a covered person or that person's authorized representative, provider or other health care professional with knowledge of the covered person's medical condition, acting on behalf of and with the covered person's consent.

S. "Health benefits plan" means a health plan or a policy, contract, certificate or agreement offered or issued by a health care insurer or plan administrator to provide, deliver, arrange for, pay for or reimburse the costs of health care services, including a traditional fee-for-service health benefits plan and coverage provided by, through or on behalf of an entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act.

T. "Health care insurer" means a person that has a valid certificate of authority in good standing issued pursuant to the Insurance Code to act as an insurer,

health maintenance organization, non-profit health benefits plan, fraternal benefit society, vision plan or pre-paid dental plan.

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

V. "Health care services" means services, supplies and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease, and includes, to the extent offered by the health benefits plan, physical and mental health services, including community-based mental health services, and services for developmental disability or developmental delay.

W. "Hearing officer, independent co-hearing officer or ICO" means a health care or other professional licensed to practice medicine or another profession who is willing to assist the superintendent as a hearing officer in external review hearings.

X. "Independent review organization (IRO)" means an entity that is appointed by the superintendent to conduct independent external reviews of adverse determinations and final adverse determinations pursuant to this rule; and which renders an independent and impartial decision.

Y. "Initial determination" means a formal written disposition by a health care insurer affecting a covered person's rights to benefits, including full or partial denial of a claim or request for coverage or its initial administrative decision.

Z. "Limited Scope dental or limited scope vision" means any vision or dental care plan as that term is defined under Section 59A-23G-2 NMSA 1978.

AA. "Managed health care bureau or **MHCB"** means the managed health care bureau within the office of the superintendent of insurance.

[~~AA~~] **BB. "Medical necessity or medically necessary"** means health care services determined by a provider, in consultation with the health care insurer, to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by the health care insurer consistent with such federal, national, and professional practice guidelines, for the diagnosis, or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury or disease.

[~~BB~~] **CC. "Office of the superintendent of insurance or OSI"** means the office of the superintendent of insurance or [~~its~~] staff of the office of superintendent of insurance.

[~~CC~~] **DD. "Post-service claim"** means a claim submitted to a health care insurer by or on behalf of a covered person after health care services have been provided to the covered person.

[~~DD~~] **EE. "Prior authorization"** (also called pre-certification) means a pre-service determination made by a health care insurer regarding a member's eligibility for services, medical necessity, benefit coverage, location or appropriateness of services, pursuant to the terms of the health care plan.

[~~EE~~] **FF. "Prospective review"** means utilization review conducted prior to provision of health care services in accordance with a health care insurer's requirement that the services be approved in advance.

[~~FF~~] **GG. "Provider"** means a duly licensed hospital or other licensed facility, physician or other health care professional authorized to furnish health care services within the scope of their license.

[~~GG~~] **HH. "Rescission of coverage"** means a cancellation or discontinuance of coverage that has retroactive effect; a cancellation or discontinuance of coverage is not a rescission if:

(1) the cancellation or discontinuance of coverage has only a prospective effect; or

(2) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or

(3) the cancellation or discontinuance of coverage is initiated by the covered person or the covered person's authorized representative and the employer or health care insurer did not, directly or indirectly, take action to influence the covered person's decision or otherwise retaliate against, interfere with, coerce, threaten or intimidate the covered person; or

(4) the cancellation or discontinuance is initiated by the health insurance exchange.

[~~HH~~] **II. "Retrospective review"** means utilization review that is not conducted prior to provision of health care services.

[~~II~~] **JJ. "Summary of benefits"** means the written materials required by Section 59A-57-4 NMSA 1978 to be given to the grievant by the health care insurer or group contract holder.

[~~JJ~~] **KK. "Superintendent"** means the superintendent of insurance, or the office of the superintendent of insurance.

[~~KK~~] **LL. "Termination of coverage"** means the cancellation or non-renewal of coverage provided by a health care insurer to a grievant, but does not include a voluntary termination by a grievant, termination initiated by the health insurance exchange, or termination of a health benefits plan that does not contain a renewal provision.

[~~LL~~] MM. **"Traditional fee-for-service indemnity benefit"** means a fee-for-service indemnity benefit, not associated with any financial incentives that encourage covered person to utilize preferred providers, to follow pre-authorization rules, to utilize prescription drug formularies, or other cost-saving procedures to obtain prescription drugs, or to otherwise comply with a plan's incentive program to lower cost and improve quality, regardless of whether the benefit is based on an indemnity form of reimbursement for services.

[~~MM~~] NN. **"Uniform standards"** means all generally accepted practice guidelines, evidence-based practice guidelines, or practice guidelines developed by the federal government, or national and professional medical societies, boards and associations; and any applicable clinical review criteria, policies, practice guidelines, or protocols developed by the health care insurer consistent with the federal, national and professional practice guidelines that are used by a health care insurer in determining whether to certify or deny a requested health care service.

[~~NN~~] OO. **"Urgent care situation"** means a situation in which the decision regarding certification of coverage shall be expedited because:

(1) the life or health of a covered person would otherwise be jeopardized;

(2) the covered person's ability to regain maximum function would otherwise be jeopardized;

(3) the physician with knowledge of the covered person's medical condition reasonably requests an expedited decision;

(4) in the opinion of the physician with knowledge of the covered person's medical condition, delay would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim;

(5) the medical exigencies of the case require an expedited decision, or

(6) the covered person's claim otherwise involves urgent care.

[~~OO~~] PP. **"Utilization review"** means a set of formal techniques designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities.

[13.10.17.7 NMAC - Rp, 13.10.17.7 NMAC, 1/1/2017; A, 11/19/2024]

13.10.17.9 GENERAL REQUIREMENTS REGARDING GRIEVANCE PROCEDURES:

A. Written grievance procedures required. Every health care insurer shall establish and maintain separate written procedures that comply with this rule to provide for the internal review of adverse determination grievances and administrative grievances.

B. Divisible grievance. If a grievance contains clearly divisible administrative and adverse determination issues, then the health care insurer shall initiate separate complaints for each issue with an explanation of the health care insurer's actions contained in one acknowledgment letter.

C. Assistance to grievants. In those instances, where a grievant requests or expresses interest in pursuing a grievance, the health care insurer shall assist the grievant to complete all the forms required to pursue internal review and shall advise the grievant that the MHCB is also available for assistance with appropriate forms and deadlines.

D. Retaliatory action prohibited. No person shall be subject to retaliatory action by the health care insurer for any reason related to a grievance.

[13.10.17.9 NMAC - Rp, 13.10.17.9 NMAC, 1/1/2017; A, 11/19/2024]

13.10.17.10 INFORMATION ABOUT GRIEVANCE PROCEDURES:

A. For covered persons/grievants. A health care insurer shall:

(1) include a clear and concise summary of the grievance procedures, both internal and external, in boldface type in all handbooks or evidences of coverage, issued to covered persons, along with a link to the full version of the grievance procedures, as found on the OSI website;

(2) when the health care insurer makes either an initial or final adverse determination or an administrative decision, provide the following to a covered person, that person's authorized representative or a provider acting on behalf of a covered person:

(a) a concise written summary of its grievance procedures;

(b) a copy of the applicable grievance forms;

(c) a link to the full version of the grievance procedures, as found on the OSI website; and

(d) a toll-free telephone number, facsimile number, e-mail and mailing addresses of the health care insurer's consumer assistance office and for the MHCB.

(3) notify covered person that a representative of the health care insurer and the MHCB are available upon request to assist covered person with grievance procedures by including such information and a toll-free telephone number for obtaining such assistance in the enrollment materials and summary of benefits issued to covered person;

(4) notify the covered person that the MHCB may only provide limited guidance regarding appropriate forms and deadlines but the MHCB does not act as a covered person's representative;

[~~(4)~~] **(5)** make available on its website or upon request, consumer education brochures and materials developed and approved by the superintendent in consultation with the health care insurer;

[~~(5)~~] **(6)** provide notice to covered person in a culturally and linguistically appropriate manner as defined in Subsection H of 13.10.17.7 NMAC;

[~~(6)~~] **(7)** provide continued coverage for an approved on-going course of treatment pending the final determination on review;

[~~(7)~~] **(8)** not reduce or terminate an approved on-going course of treatment without first notifying the grievant sufficiently in advance of the reduction or termination to allow a covered person to request a review and obtain a final determination on review of the proposed reduction or termination; and

[~~(8)~~] **(9)** allow covered person in urgent care situations and those receiving an on-going course of treatment that the health care insurer seeks to reduce or terminate to proceed with an expedited IRO review at the same time as the internal review process.

B. For providers. A health care insurer shall inform all providers of the grievance procedures and shall make all necessary forms available upon request, including consumer education brochures and materials developed or approved by the superintendent for distribution. These items may be provided in paper format or electronically.

C. Special needs. Information about grievance procedures must be provided in accordance with the Americans with Disabilities Act, 42 U.S.C. Sections 12101, *et seq.*; the Patient Protection and Affordable Care Act of 2010, P.L. 111-152 as codified in the U.S.C.; and 13.10.13 NMAC, and MHCB, particularly 13.10.13.29 NMAC, Cultural and Linguistic Diversity. [13.10.17.10 NMAC - N, 13.10.17.10 NMAC, 1/1/2017; A, 11/19/2024]

13.10.17.15 NOTICE FOLLOWING FIRST LEVEL INTERNAL REVIEW OF ADVERSE DETERMINATIONS:

A. Notice requirements. The health care insurer shall notify the grievant and provider of the decision within 24 hours by telephone and in writing by mail or electronic communication sent within one day after the initial attempt to provide telephonic notice, unless earlier notice is required by the medical exigencies of the case.

B. Contents of notice. If the initial decision denying certification is upheld in whole or in part, then the health care insurer's notice shall include the following:

(1) the name, title and qualifying credentials of the person who provided the review;

(2) a statement of the reviewer's understanding of the nature of the grievance;

(3) a description of the evidence relied on by the reviewer in reaching a decision;

(4) if an adverse determination is upheld based on a determination that the requested service is experimental, investigational or not medically necessary, then:

(a) clearly and completely explain why the requested health care service is not medically necessary, is experimental or investigational; a statement that the health care service is not medically necessary, is experimental or investigational will not be sufficient; and

(b) include a citation to the uniform standards relevant to the grievant's medical condition and an explanation of whether each standard supported or did not support the determination that the requested service is experimental, investigational, or is not medically necessary.

(5) if an adverse determination is upheld based on a lack of coverage, identify all health benefits plan provisions relied on in making the adverse determination, and clearly and completely explain why the requested health care service is not covered by any provision of the health benefits plan; a statement that the requested health care service is not covered by the health benefits plan will not be sufficient;

(6) if the service has already been provided, then include the date of service, the provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

(7) notice that the grievant may request either:

(a) an internal panel review within [~~five~~] 15 days; or

(b) an external review within four months.

(8) if the adverse determination involves an urgent care situation, advise that the grievant may immediately request an expedited IRO external review;

(9) if the grievant is covered by the New Mexico Health Care Purchasing Act, then advise the grievant that an internal panel review is required before the grievance will be reviewed by the grievant's specific review board and only then may the grievant request an external review; and

(10) describe the procedures and provide all necessary grievance forms to the grievant for requesting an internal panel review, for requesting an external review, or for requesting an expedited review.

C. Information for requesting an external review. Notice of the grievant's right to request an external review shall include the address and telephone number of the MHCB, a description of all procedures and time deadlines necessary to pursue an external review, copies of all forms required to initiate an external review and the following notice:

"*We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed, at no cost to you, by an impartial Independent Review Organization (IRO)*

who has no association with us and is appointed by the Office of Superintendent of Insurance (OSI). If our decision involved making a judgment as to the medical necessity, experimental nature or investigational nature of the requested service, or the appropriateness, health care setting, or level of care, then the [~~IRO~~] Independent Review Organization (IRO) review will be performed by one or more health care professionals. You may also request an external review by OSI for rescissions or for adverse determinations that do not involve medical judgment. For more information contact OSI by electronic mail at [~~mhcb.grievance@state.nm.us~~] mhcb.grievance@osi.nm.gov; by telephone at (505) 827-4601; or toll- free at 1-(855)-427-5674. You may also visit the OSI website at http://www.osi.state.nm.us for more information."

D. Grievance discontinued. If the grievant informs the health care insurer by telephone that the grievant does not wish to pursue the grievance, then the health care insurer's notice shall include confirmation of the grievant's decision not to pursue the matter further.

E. Grievant's decision unknown. If the health care insurer is unable to contact the grievant by telephone within one day of the decision to uphold the adverse determination, the health care insurer's written notice shall include a self-addressed stamped envelope and response form which asks whether the grievant wishes to request either an internal panel review or an external review. The form shall provide check boxes as follows:

Do you want to appeal the decision?

☐ No

☐ Yes

(If yes, then please select one of the following:)

☐ Internal panel review requested

☐ External review requested

F. Extending the timeframe for requesting a standard review. If the grievant does not make an immediate decision to pursue the grievance, or the grievant has requested additional time to supply supporting documents or information, or postponement pursuant to Subsection F of 13.10.17.14 NMAC, the timeframe shall be extended to include the additional time if requested by the grievant.

[13.10.17.15 NMAC - N, 1/1/2017; A, 11/19/2024]

13.10.17.17 NOTICE OF INTERNAL PANEL REVIEW DECISION:

A. Notice requirements. The health care insurer shall notify the grievant and provider of the internal panel's decision within 24 hours by telephone and in writing by mail or electronic communication sent within one day after the initial attempt to provide telephonic notice, unless earlier notice is required by the medical exigencies of the case.

B. Contents of notice. If the initial decision denying certification is upheld in whole or in part, then the panel's written notice shall contain:

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

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

(3) a description of the evidence relied on by the internal review panel in reaching its decision;

(4) if an adverse determination is upheld based on a determination that the requested service is experimental, investigational or not medically necessary, then:

(a) clearly and completely explain why the requested health care service is not medically necessary, is experimental or investigational; a statement that the health care service is not medically necessary, is experimental or investigational will not be sufficient; and

(b) include a citation to the uniform standards relevant to the grievant's medical condition and an explanation of whether each supported or did not support the decision regarding a determination that the requested service is experimental, investigational, or medically necessary.

(5) if an adverse determination is upheld based on a lack of coverage, identify all health benefits plan provisions relied on in making the adverse determination, and clearly and completely explain why the requested health care service is not covered by any provision of the health benefits plan; a statement that the requested health care service is not covered by the health benefits plan will not be sufficient;

(6) if the service has already been provided, then include the date of service, the provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

(7) if the grievant is covered by the New Mexico Health Care Purchasing Act, then advise the grievant of the grievant's right to request review from and in the manner designated by an entity authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act and that the entity must review the grievant's request before grievant can request an external review through OSI;

(8) if the adverse determination involved medical judgment, including a determination based on medical necessity, appropriateness, health care setting, level of care, effectiveness or that the requested health care service is experimental or investigational, notice of the grievant's right to

request external review by an IRO within four months, including the address and telephone number of the MHCB, a description of all procedures necessary to pursue an IRO external review, copies of any forms required to initiate an IRO external review; or

(9) if the adverse determination did not involve medical judgment, notice of the grievant's right to request external review by the superintendent and copies of any forms required to initiate an external review by the superintendent.

C. Information for requesting an external review. Notice of the grievant's right to request an external review shall include the address and telephone number of the MHCB, a description of all procedures and time deadlines necessary to pursue an external review, copies of all forms required to initiate an external review and the following language:

"*We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed, at no cost to you, by an impartial Independent Review Organization (IRO) who has no association with us and is appointed by the Office of Superintendent of Insurance (OSI). If our decision involved making a judgment as to the medical necessity, the experimental nature or the investigational nature of the requested service, or the appropriateness, health care setting, or level of care, then the [~~IRO~~] Independent Review Organization (IRO) review will be performed by one or more health care professionals. You may also request an external review by OSI for rescission or adverse determinations that do not involve medical judgment. For more information contact OSI by electronic mail at [~~mhcb.grievance@state.nm.us~~] mhcb.grievance@osi.nm.gov; by telephone at (505) 827-4601; or toll- free at 1-(855)-427-5674. You may also visit the OSI website at http://www.osi.state.nm.us for more information.*"

D. Grievance discontinued. If the grievant informs the health care insurer by telephone that the grievant does not wish to pursue the grievance, the health care insurer's notice shall include written confirmation of the grievant's decision not to pursue the matter further.

E. Grievant's decision unknown. If the health care insurer is unable to contact the grievant by telephone within one day of the panel's decision to uphold the adverse determination, the health care insurer's written notice shall include all information necessary to request an external review.

[13.10.17.17 NMAC - Rp, 13.10.17.22 NMAC, 1/1/2017; A, 11/19/2024]

13.10.17.18 ADDITIONAL REVIEW BY ENTITIES SUBJECT TO THE NEW MEXICO HEALTH CARE PURCHASING ACT:

A. Applicability. This section applies only to entities and grievants subject to the New Mexico Health Care Purchasing Act (public employees and retirees, public school employees and retirees only).

B. Eligibility for review. A grievant who remains dissatisfied with the decision of the health care insurer after the completion of the internal panel review must have their claim reviewed in accordance with any review process established by the entity providing their health care benefits pursuant to the New Mexico Health Care Purchasing Act.

C. Decision to uphold. If the health care insurer has upheld the initial adverse determination to deny the requested health care service at both the first level internal review and the internal panel review, the health care insurer shall notify the grievant that their grievance must be reviewed by their specific review board before their grievance may be eligible for an external review through OSI including an IRO review, as defined by their policy. The health care insurer shall ascertain whether the grievant wishes to pursue the grievance before the specific review board.

(1) If the grievant does not wish to pursue the grievance, the health care insurer shall include confirmation of the grievant's decision not to pursue the matter further with the written notification of the health care insurer's decision as described in Subsection B of 13.10.17.17 NMAC.

(2) If the health care insurer is unable to contact the grievant by telephone within one day of the panel's decision to uphold the adverse determination, the health care insurer shall send a written inquiry, as described in Subsection D of 13.10.17.17 NMAC.

(3) If the grievant responds affirmatively to the telephone or written inquiry the matter will proceed to a review by the grievant's specific review board, according to the procedures contained in the grievant's policy handbook.

D. Extending the timeframe for review. If the grievant does not make an immediate decision to pursue the grievance, the grievant has requested additional time to supply supporting documents or information, or has asked for postponement, the timeframe shall be extended to include the additional time required by the grievant.

E. Notice following review by the specific review board.

(1) Certification. Upon receipt of notice from grievant's specific review board that the requested benefit shall be certified, the health care insurer shall provide coverage in accordance to the review board's decision.

(2) Adverse determination upheld. Upon receipt of notice that grievant's specific review board upholds the decision denying certification, then MHCB shall contact the grievant to determine whether grievant wishes to request an external review. If the MHCB

is unable to contact the grievant by telephone within 24 hours, then MHCB will attempt to contact the grievant and the provider in writing by mail or electronically on the following day.
[13.10.17.18 NMAC - N, 1/1/2017; A, 11/19/2024]

13.10.17.19 IRO REVIEW OF AN ADVERSE DETERMINATION:

A. Right to external IRO review. Every grievant who is dissatisfied with an adverse determination following internal review of a grievance that involves medical judgment, including a determination based on medical necessity, appropriateness, health care setting, level of care, effectiveness or that the requested health care service is experimental, investigational or unproven for a particular medical condition may request an external review by an impartial IRO appointed by the superintendent at no cost to the grievant.

B. Exhaustion of internal review process. The superintendent may require the grievant to exhaust any required grievance procedures adopted by the health care insurer or the entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act, as appropriate, before accepting a grievance for IRO review.

C. Deemed exhaustion. If exhaustion of internal reviews is required prior to IRO review, exhaustion is unnecessary and the internal reviews process will be deemed exhausted if:

(1) the health care insurer waives the exhaustion requirement;

(2) the health care insurer is considered to have exhausted the internal review process by failing to comply with the requirements of the internal review process; or

(3) the grievant simultaneously requests an expedited internal review and an expedited IRO review.

D. Exception to exhaustion requirement.

(1) Notwithstanding Subsection C of 13.10.17.19 NMAC, the internal review process will not be deemed exhausted based on violations by the health care insurer that are *de minimus* and do not cause, and are not likely to cause, prejudice or harm to the grievant, so long as the health care insurer demonstrates that the violation was for good cause or due to matters beyond the control of the health care insurer, and that the violation occurred in the context of an on-going, good faith exchange of information between the health care insurer and the grievant. This exception is not available if the violation is part of a pattern or practice of violations by the health care insurer, as determined by the superintendent.

(2) The grievant may request a written explanation of the violation from the health care insurer, and the health care insurer must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal review process to be deemed exhausted. If an external reviewer or a court rejects the grievant's request for immediate review on the basis that the health care insurer met the standards for the exception under Paragraph (1) of Subsection D of 13.10.17.19 NMAC, the grievant has the right to re-submit and pursue a request for review of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the health care insurer shall provide the grievant with notice of the opportunity to re-submit and pursue the internal review of the claim. Time periods for re-filing the claim shall begin to run upon grievant's receipt of such notice.

E. IRO fees. The health care insurer against which a request for external review has been filed shall be responsible for paying the fees of the IRO. The health care insurer shall remit payment to the IRO within 30 days after its receipt of the invoice.

(1) The superintendent shall determine the reasonable compensation for IROs and shall publish a schedule of IRO compensation by bulletin.

(2) Upon completion of [~~an external~~] the review, the IRO shall submit its invoice directly to the health care insurer.

F. In reaching a decision, the assigned IRO is not bound by any decisions or conclusions reached during the health care insurer's utilization review process or the health care insurer's internal grievance process.

G. Nothing in this rule shall preclude the health care insurer and grievant from resolving the matter prior to completion of the IRO review.

H. A grievant may not file a subsequent request for external review by an IRO involving the same adverse determination for which the grievant has already received an external IRO review under this rule.
[13.10.17.19 NMAC - Rp, 13.10.17.24 NMAC, 1/1/2017; A, 11/19/2024]

13.10.17.21 INITIATING AN IRO REVIEW OF AN ADVERSE DETERMINATION:

A. Expedited IRO review. If required by the medical exigencies of the case, a grievant or provider may telephonically request an expedited review by an IRO by calling the MHCB at (505) 827-4601 or 1-(855)-427-5674. A complaint form with signed medical release must also be provided. Request for expedited external review filed with the OSI must include a statement from the grievant's treating physician.

B. Standard IRO review. To initiate an IRO review, a grievant must file a written request for an IRO review within four months from receipt of the written notice of the final internal review decision unless extended by the superintendent for good cause shown. The request shall be:

(1) mailed to

the superintendent, [~~attn.~~] attention: managed health care bureau - external review request, office of superintendent of insurance, P.O. Box 1689, 1120 Paseo de Peralta, Santa Fe, NM 87504-1689; or

(2) e-mailed to [~~mhcb.grievance@state.nm.us~~] mhcb.grievance@osi.nm.gov, subject: external review request; or

(3) faxed to the superintendent, [~~attn.~~] attention: managed health care bureau - external review request at [~~(505) 827-4734~~] (505) 827-4253; or

(4) completed on-line with an OSI complaint form available at http://www.osi.state.nm.us/.

C. Duty to re-direct request. Any request for external review sent to the health care insurer instead of to OSI shall be forwarded to the OSI by the health care insurer within three days after receipt. Requests for expedited review should be forwarded to OSI as required by the medical exigencies of the case.

D. Documents required to be filed by the grievant. The grievant shall file the request for IRO review on the forms provided to the grievant by the health care insurer, OSI, or an entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act, and shall also file:

(1) a copy of the notice(s) of all prior review decisions; and

(2) a fully executed release form authorizing the IRO or the superintendent to obtain any necessary medical records from the health care insurer or any other relevant provider.

[13.10.17.21 NMAC - Rp, 13.10.17.18 NMAC, 1/1/2017; A, 11/19/2024]

13.10.17.22 TIMEFRAMES AND PROCESSES FOR IRO REVIEW:

A. Type of IRO review. The IRO shall conduct either a standard or expedited review of the adverse determination, as required by the medical exigencies of the case.

(1) The IRO shall complete an expedited external review and provide notice of its decision to the grievant, the provider, the health care insurer, and the superintendent as required by the medical exigencies of the case as soon as possible, but in no case later than 72 hours after appointment by the superintendent. If notice of the IRO's decision is initially provided by telephone, written notice of the decision shall be provided within 48 hours after the telephone notification.

(2) The IRO shall complete a standard external review and provide written notice of its decision to the grievant, the provider, the health care insurer and the superintendent within 20 days after appointment by the superintendent.

B. Expedited IRO review, timeframe and process.

(1) In cases involving an urgent care claim, the superintendent shall immediately upon receipt of a request for an expedited IRO review send the grievant an acknowledgment that the request has been received and send a copy of the request to the health insurer.

(2) Within 24 hours or the time limit set by the superintendent following receipt of a request for an expedited IRO review from the superintendent, the health care insurer shall complete a preliminary review of the matter to determine whether the request is eligible for IRO review, and shall report immediately to OSI upon completion of the preliminary review, as follows:

(a) the grievant is or was a covered person in the health benefit plan at the time the health care service was requested;

(b) the health care service that is the subject of the request for IRO review reasonably appears to be a covered benefit under the grievant's health benefit plan, but for a determination by the health care insurer that the requested service is not covered because it is experimental, investigational, or not medically necessary; and

(c) the grievant has or is not required to exhaust the health carrier's internal grievance process.

(3) If the request is not complete, the health care insurer shall inform the grievant, provider and the superintendent telephonically and electronically and include in the notice what information or materials are needed to make the request complete.

(4) If the request is not eligible for IRO review, the health care insurer shall inform the grievant, provider and the superintendent telephonically and electronically and include in the notice the reasons for ineligibility and a statement that the health care insurer's determination of ineligibility may be appealed to the superintendent.

(5) MHCB will confirm or obtain from the grievant all information and forms required to process an expedited IRO review, including the signed release form.

(6) Upon receipt of the health care insurer's notice that a request is complete and eligible for IRO review and the confirmation from MHCB, the superintendent will immediately randomly assign an IRO from the superintendent's list of approved IROs to conduct an expedited review, and shall:

(a) notify the health care insurer of the name of the assigned IRO; and

(b) notify the grievant and the provider of the name of the assigned IRO, that the health care insurer will provide to the IRO all of the documents and information considered in making the adverse determination, and that the grievant and provider may provide additional information.

(7) The superintendent may determine that a request is eligible for an expedited IRO review notwithstanding a health

care insurer's initial determination that the request is incomplete or ineligible. In making an eligibility determination, the superintendent's decision shall be made in accordance with the terms of the grievant's health benefit plan.

(8) MHCB will immediately provide to the assigned IRO and to the health care insurer all information and forms obtained from the grievant, including a signed release form.

(9) Within 24 hours from the date of the notice from the superintendent that the IRO has been appointed, the grievant or the provider may also submit additional documentation or information to the IRO; the IRO shall immediately forward any documentation or information received from the grievant to the health care insurer.

(10) Upon receipt of the superintendent's notice that an IRO has been appointed, the health care insurer shall within 24 hours provide to the assigned IRO, any information considered in making the adverse determination, including, but not limited to:

(a) the summary of benefits;

(b) the complete health benefits plan, which may be in the form of a member handbook/evidence of coverage;

(c) all pertinent medical records, internal review decisions and rationales, consulting physician reports, and documents and information submitted by the grievant and health care insurer;

(d) uniform standards relevant to the grievant's medical condition that were used by the internal panel in reviewing the adverse determination; and

(e) any other documents, records, and information relevant to the adverse determination and the internal review decision(s).

(11) Failure by the health care insurer to provide the documents and information required by this rule within the time specified shall not delay the conduct of the IRO external review. If the health care insurer fails to provide the documents and information within the time specified, the assigned IRO may terminate the review and make a decision to reverse the adverse determination.

C. Standard IRO review, timeframe and process.

(1) Within one day after the date of receipt of a request for an IRO review, the superintendent shall send the grievant an acknowledgment that the request has been received and send a copy of the request to the health insurer.

(2) Within five days following the receipt of the IRO review request from the superintendent, the health insurer shall complete a preliminary review of the request to determine whether the request is eligible for IRO review, as follows:

(a) the grievant is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided;

(b) the health care service that is the subject of the request for IRO review reasonably appears to be a covered service under the grievant's health benefit plan, but for a determination by the health care insurer that the requested health care service is not covered because it is experimental, investigational, or not medically necessary;

(c) for experimental or investigational adverse determinations, the grievant's treating physician certified, in writing, that one of the following applies:

(i) standard health care services or treatments have not been effective in improving the condition of the grievant;

(ii) standard health care services or treatments are not medically appropriate for the grievant;

(iii) there is no available standard health care service or treatment covered by the health benefits plan that is more beneficial than the recommended or requested health care service or treatment;

(iv) the health care service or treatment requested is likely to be more beneficial to the grievant, in the physician's opinion, than any available standard health care services or treatments; or

(v) the grievant's treating physician, who is licensed, board certified or board eligible to practice in the area of medicine appropriate to treat the grievant's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested is likely to be more beneficial to the grievant than any available standard health care services or treatments.

(d) the grievant has exhausted or is not required to exhaust the health care insurer's internal grievance process; and

(e) the grievant has provided all the information and forms required to process an IRO review, including the signed release form.

(3) Upon completion of the preliminary review, the health care insurer shall notify the superintendent and grievant in writing within one day whether:

(a) the request is complete; and

(b) the request is eligible for IRO review.

(4) If the request:

(a) is not complete, the health care insurer shall inform the grievant and the superintendent in writing and include in the notice what information or material are needed to make the request complete; or

(b) is not eligible for an IRO review, the health care insurer shall inform the grievant and the superintendent in writing and include in the notice the reasons for its ineligibility.

(5) The notice of initial determination shall include a statement informing the grievant that a health care insurer's initial determination of ineligibility for IRO review may be appealed to the superintendent.

(6) The superintendent may determine that a request is eligible for an IRO review notwithstanding a health care insurer's initial determination that the request is ineligible and require that it be referred to an IRO. In making an eligibility determination, the superintendent's decision shall be made in accordance with the terms of the grievant's health benefit plan.

(6) Even after the superintendent assigns a grievance to an IRO for review, the MHCB may attempt to resolve the grievance between the health care insurer and the grievant. If the matter is successfully resolved, OSI will immediately notify the IRO to terminate work.

D. Assignment of IRO by superintendent.

(1) Within one day of receipt of a notice that the health care insurer has determined a request is eligible for an IRO review, the superintendent shall:

(a) randomly assign an IRO from the superintendent's list of approved IROs to conduct the review;

(b) notify the health care insurer of the name of the assigned IRO;

(c) notify the grievant in writing that the request is eligible for an IRO external review, the name of the assigned IRO, and that the health care insurer will provide all of the documents and information considered by the health care insurer in making the adverse determination; and

(d) notify the grievant that the grievant may submit in writing to the assigned IRO within five days following the date of receipt of the notice, any additional information that the IRO shall consider when conducting the review. The IRO is not required to, but may, accept and consider additional information submitted after five days.

(2) If the adverse determination is based on a determination that the requested service is experimental, investigational, or not medically necessary, then the superintendent shall direct the IRO to utilize a panel of appropriate clinical peer(s) of the same or similar specialty as would typically manage the case being reviewed.

(3) Within one day after the receipt of the notice of assignment by the superintendent to conduct the external review, the assigned IRO shall select [~~one clinical reviewer or for experimental or investigational adverse determinations, three clinical reviewers to conduct the external review.~~] up to three clinical reviewers.

(4) Within five days following the notice of the assigned IRO, the health care insurer shall provide to the assigned IRO all documents and any information considered in making the adverse determination, including, but not limited to:

(a) the summary of benefits;

(b) the complete health benefits plan, which may be in the form of a member handbook/evidence of coverage;

(c) all pertinent medical records, internal review decisions and rationales, consulting physician reports, and documents and information submitted by the grievant and health care insurer;

(d) uniform standards relevant to the grievant's medical condition that were used by the internal panel in reviewing the adverse determination; and

(e) any other documents, records, and information relevant to the adverse determination and the internal review decision(s).

(5) Failure by the health care insurer to provide the documents and information required by this rule within the time specified shall not delay the conduct of the external review. If the health care insurer fails to provide the documents and information within the time specified, the assigned IRO may terminate the review and make a decision to reverse the adverse determination. Within one day after making such a decision, the IRO shall notify the grievant, the provider, the health care insurer, and the superintendent.

(6) If the grievant provides additional supporting documents or information to the IRO:

(a) The IRO shall send any information received from grievant to the health care insurer within one day.

(b) Upon receipt of such information, the health care insurer may reconsider its adverse determination.

(7) If, upon such review, the health care insurer reverses its prior decision, it shall within one day provide written notification of its decision to the grievant, the provider, the assigned IRO and the superintendent.

(a) If the health care insurer reverses its prior decision, the assigned IRO shall terminate its review upon receipt of the notice from the health care insurer.

(b) Upon reversing its prior decision, the health care insurer shall approve coverage for the health care service subject to any applicable cost sharing including co-payments, co-insurance and deductible amounts for which the grievant is responsible.

(c) The health care insurer shall compensate the IRO according to the published fee schedule whenever the IRO review is terminated prior to

completion.
[13.10.17.22 NMAC - Rp, 13.10.17.27 NMAC, 1/1/2017; A, 11/19/2024]

13.10.17.23 THE FINAL DECISION OF THE IRO AND GRIEVANT'S RIGHT TO HEARING AFTER FINAL IRO DECISION:

A. Independent decision. In reaching its decision, the IRO is not bound by the prior decision of the health care insurer. In addition to the documents and information provided to the IRO by the health care insurer and the grievant and to the extent such documents are available, each reviewer shall consider the following in reaching its decision:

(1) the grievant's medical records;

(2) the attending health care professional's recommendation;

(3) consulting reports from appropriate health care professionals and other documents submitted by the health care insurer, the grievant, or the treating health care professional;

(4) the terms of coverage under the applicable health benefit plan to ensure that the IRO's decision is not contrary to the terms of coverage;

(5) the most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

(6) any applicable clinical review criteria and policies developed and used by the health care insurer; and

(7) the opinion of the IRO's clinical reviewer(s) after considering the information received.

B. Opinion of clinical reviewer. Each clinical reviewer selected shall provide an opinion to the assigned IRO as to whether the recommended or requested health care service should be covered as follows:

(1) for a standard external review, each clinical reviewer shall provide a written opinion to the IRO within the time constraints set by this rule;

(2) for an expedited external review, each clinical reviewer shall provide an opinion orally or in writing to the IRO as expeditiously as the covered person's medical condition or circumstances requires. If the opinion is provided orally, each clinical reviewer shall provide a written opinion to the IRO within 48 hours after providing the oral opinion; and

(3) each clinical reviewer's written opinion shall include the following information:

(a) a description of the covered person's medical condition;

(b) whether there is sufficient evidence to demonstrate that the requested health care service is more likely than not to be more beneficial to the covered person than any available standard health care services and that the adverse risks of the requested health care service would not be substantially increased over those of available standard health care services;

(c) a description and analysis of any medical or scientific evidence considered in reaching the opinion;

(d) a description and analysis of any evidence-based standards;

(e) the reviewer's rationale for the opinion; and

(f) whether the recommended or requested health care service has been approved by the federal food and drug administration, if applicable, for the condition.

C. Decision of the IRO. Based upon the opinion of [~~each~~] the clinical [~~reviewer~~] reviewers, the IRO shall issue notice of its decision in the manner set forth in this rule.

(1) If a majority of clinical reviewers recommend that the requested health care service should be covered, the IRO shall reverse the health care insurer's adverse determination.

(2) If a majority of clinical reviewers recommend that the requested health care service should not be covered, the IRO shall uphold the health care insurer's adverse determination.

D. Content of IRO's notice. Notice of the IRO's decision shall be sent to the grievant, the provider, the health care insurer, and the superintendent and shall include:

(1) a general description of the reason for the request for external review;

(2) the date the IRO was appointed;

(3) the date the review by the IRO was completed;

(4) the principal reason(s) for its decision, including any applicable evidence-based standards that were the basis for the decision;

(5) reference to the evidence or documentation that was considered in reaching the decisions;

(6) the rationale for the decision; and

(7) the written opinion of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for each reviewer's recommendation.

E. Binding decision. The decision of the IRO is binding upon the health care insurer except to the extent that the health care insurer may pursue other remedies under applicable state and federal law. The decision is also binding upon the grievant except to the extent that the grievant may pursue other remedies under applicable state and federal law, including the grievant's right to appeal to the superintendent for a hearing.

(1) This requirement that the decision is binding shall not preclude the health

care insurer from making payment on the claim or otherwise providing benefits at any time, including after an IRO's decision or following an external review by the superintendent that denies the claim or otherwise fails to require such payment or benefits.

(2) Upon receipt of a decision by an IRO reversing an adverse determination, the health care insurer shall approve coverage for the health care service for which the IRO review was conducted, subject to any applicable co-payment, co-insurance and deductible amounts for which the grievant is responsible without delay, regardless of whether the health care insurer intends to seek judicial review of the external review decision and unless or until there is a final judicial decision otherwise.

[13.10.17.23 NMAC - Rp, 13.10.17.30 NMAC, 1/1/2017; A, 11/19/2024]

13.10.17.24 SUPERINTENDENT'S HEARING PROCEDURES FOR ADVERSE DETERMINATIONS:

A. Grievant's rights.

(1) Following the IRO's decision, the MHCB shall notify the grievant that if the grievant is dissatisfied with the IRO's decision, the grievant may request a hearing from the superintendent within 20 days of the IRO decision. MHCB will provide the grievant with all forms necessary to request a hearing by the superintendent.

(2) Any grievant whose adverse determination grievance involved a rescission of coverage or did not involve medical judgment may request a hearing by the superintendent within four months of receiving the health care insurer's internal decision. The health care insurer will provide the grievant will all forms necessary to request a hearing by the superintendent.

B. Review of request for hearing. Upon receipt of a request for a hearing, the superintendent will review the request and may grant a hearing if the following criteria are met:

(1) the grievant has exhausted the internal review process or is not required to exhaust the internal review process and, if applicable, the external IRO review process;

(2) the grievant has timely requested review by the superintendent;

(3) the grievant has provided a signed release and all forms and documents required to process the request, and

(4) the health care service that is the subject of the request reasonably appears to be a covered benefit under the applicable health benefits plan.

C. Request incomplete. If the request for an external hearing is incomplete, MHCB staff shall immediately notify the grievant and request that the grievant submit the information required to complete the request for external review within a specified period of time. If the grievant fails to provide the required information within the specified time, the request will be deemed to not meet the criteria prescribed by this rule.

D. Request does not meet criteria. If the request for an external hearing does not meet the criteria prescribed by this rule, MHCB staff shall so inform the superintendent. The superintendent shall notify the grievant and the health care insurer that the request does not meet the criteria for external hearing and is thereby denied.

E. Request meets criteria. If the request for external review is complete and meets the criteria prescribed by this rule, MHCB staff shall so inform the superintendent. The superintendent shall notify the grievant and the health care insurer that the request meets the criteria for external review and that an informal hearing pursuant to Section 59A-4-18 NMSA 1978 and this rule has been set to consider the request. Prior to the hearing, insurance division staff shall attempt to informally resolve the grievance in accordance with Section 12-8-10 NMSA 1978.

F. Notice of hearing. For an expedited review, the notice of hearing shall be given to the grievant, the provider and the health care insurer telephonically. For a standard review, notice of the hearing shall be provided telephonically, and in writing by mail or electronically no less than 10 days prior to the hearing date. The notice shall state the date, time, and place of the hearing and the matters to be considered and shall advise the parties of their respective rights. The superintendent shall not unreasonably deny a request for postponement of the hearing made by the grievant or the health care insurer. If the grievant wishes to supply supporting documents or information subsequent to the filing of the request for a hearing with the superintendent, the timeframes for the hearing shall be extended up to 90 days from the receipt of the request or until the grievant submits all supporting documents, whichever occurs first.

G. Timeframe for completion of hearing. The superintendent shall complete the review within the following timeframes:

(1) an expedited review shall be completed no later than 72 hours after receipt of the complete request, or as required by the exigencies of the matter under review; and

(2) a standard review shall be completed within 45 days after receipt of the complete request.

H. Conduct of hearing. The superintendent may designate a hearing officer who shall be an attorney licensed to practice in New Mexico. The hearing may be conducted by telephone conference call, video conferencing, or other appropriate technology at OSI's expense.

(1) Co-hearing officers. The superintendent may in addition, also designate two [~~ICOs~~] independent co-hearing officers (ICOs) who shall be licensed health care professionals and who shall maintain independence and impartiality in the process. If the

superintendent designates two ICOs, at least one of them shall practice in a specialty that would typically manage the case that is the subject of the grievance.

(2) Powers. The superintendent or attorney hearing officer shall regulate the proceedings and perform all acts and take all measures necessary or proper for the efficient conduct of the hearing. The superintendent or attorney hearing officer may:

(a) require the production of additional records, documents and writings relevant to the subject of the grievance;

(b) exclude any irrelevant, immaterial or unduly repetitious evidence; and

(c) if the grievant or health care insurer fails to appear, proceed with the hearing, dismiss the matter for good cause or adjourn the proceedings to a future date, giving notice of the adjournment to the absent party.

(3) Staff participation. Staff may attend the hearing, ask questions and otherwise solicit evidence from the parties, but shall not be present during deliberations among the superintendent or his designated hearing officer, and any ICOs.

(4) Testimony. Testimony at the hearing shall be taken under oath. The superintendent or hearing officers may call and examine the grievant, the health care insurer and other witnesses.

(5) Hearing recorded. The hearing shall be stenographically recorded at OSI's expense.

(6) Rights of parties. Both the grievant and the health care insurer have the right to:

(a) attend the hearing; the health care insurer shall designate a person to attend on its behalf, and the grievant may designate a person to attend on grievant's behalf if the grievant chooses not to attend personally;

(b) be assisted or represented by an attorney or other person;

(c) call, examine and cross-examine witnesses; and

(d) submit to the ICO, prior to the scheduled hearing, in writing, additional information that the ICO must consider when conducting the internal review hearing, and require that the information be submitted to the health care insurer and the MHCB staff.

(7) Stipulation. The grievant and the health care insurer shall each stipulate on the record that the hearing officers shall be released from civil liability for all communications, findings, opinions and conclusions made in the course and scope of the external review.

I. New Mexico health care plan representative. If a grievant is insured pursuant to the New Mexico Health Care Purchasing Act and the grievant requests a hearing, if a representative from the self-insured plan is not present at any pre-hearing conference or at the hearing required by OSI, the health care insurer will be deemed to speak on behalf of the self-insured plan.

[13.10.17.24 NMAC - N, 1/1/2017; A, 11/19/2024]

13.10.17.31 REQUIREMENTS FOR EXTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCE:

A. Deadline for filing request. To initiate an external review, a grievant must file a written request for external review with the superintendent within 20 days after receipt of the written notice of the reconsideration committee's decision. The grievant shall file the request for external review on the forms provided by the health care insurer, and submitted as follows:

(1) mailed to the superintendent, [~~attn.~~] attention: managed health care bureau - external review request, office of superintendent of insurance, P.O. Box 1689, 1120 Paseo de Peralta, Santa Fe, NM 87504-1689;

(2) e-mailed to [~~mhcb.grievance@state.nm.us~~] mhcb.grievance@osi.nm.gov, subject: external review request;

(3) faxed to the superintendent, [~~attn.~~] attention: managed health care bureau - external review request at [~~(505) 827-4734~~] (505) 827-4253; or

(4) completed on-line using an OSI complaint form available on website of the OSI.

B. Other filings. The grievant may also file any other supporting documents or information the grievant wishes to submit to the superintendent for review.

C. Extending timeframes for external review. If grievant wishes to supply supporting documents or information subsequent to the filing of the request for external review, the timeframes for external review shall be extended up to 90 days from the receipt of the complaint form, or until the grievant submits all supporting documents, whichever occurs first.

[13.10.17.31 NMAC - Rp, 13.10.17.39 NMAC, 1/1/2017; A, 11/19/2024]

13.10.17.33 REVIEW OF ADMINISTRATIVE GRIEVANCE BY SUPERINTENDENT: The superintendent shall review the documents submitted by the health care insurer and the grievant, and may conduct an investigation, or inquiry, or consult with the grievant, and the health care insurer, as appropriate. The superintendent shall issue a written decision on the administrative grievance within [~~45~~] 60 days after receipt of the complete request for external review.

[13.10.17.33 NMAC - Rp, 13.10.17.41 NMAC, 1/1/2017; A, 11/19/2024]

WORKFORCE SOLUTIONS, DEPARTMENT OF

This is an amendment to 11.3.300 NMAC Section 25 effective 11/19/2024.

11.3.300.325 OVERPAYMENTS AND [~~WAIVER~~] WAIVERS OF OVERPAYMENTS [~~PURSUANT TO THE TRADE ACTS OR ANY ENACTED FEDERAL EXTENSION PROGRAM~~]:

A. Trade acts or any enacted federal extension program overpayment waivers: The department shall use the process set forth [~~herein~~] in this subsection to evaluate disputes of overpayments paid under the Trade Acts, the Trade Adjustment Assistance (TAA), Trade Readjustment Assistance (TRA), Federal Extended Benefits, or any enacted federal extension program under the following circumstances:

(1) When a decision of the department results in an overpayment, an appealable determination will be sent to the claimant. The claimant may file an appeal no later than 15 days from the date of the determination in accordance with 11.3.500 NMAC.

(2) At the department's discretion, a request for review of an overpayment may be administratively initiated to determine if a waiver of overpayment will be approved. A waiver will be approved if the department determines that:

(a) the application was made timely;

(b) payment was made without the fault of the claimant; and

(c) requiring repayment would be contrary to equity and good conscience.

(3) The department's affirmative finding of any one of the following factors of fault precludes a waiver:

(a) that the claimant knowingly made a material misrepresentation, which misrepresentation resulted in the overpayment; or

(b) that the claimant knowingly failed to disclose a material fact, which failure to disclose resulted in the overpayment; or

(c) that the claimant knew or should have known that he was not eligible for the payment; or

(d) that the department has previously issued a determination of fraud in regards to the overpayment.

(4) The department shall consider the following factors in determining whether, in equity and good conscience, the department should require repayment:

(a) whether the overpayment was the result of a decision on appeal;

(b) whether the claimant was given notice that repayment would be required in the event of reversal on appeal;

(c) whether the recovery of the overpayment would cause an extraordinary and lasting financial hardship to the claimant, resulting in the claimant's inability to obtain minimal necessities of food, medicine and shelter for at least 30 days and period of financial hardship lasting at least three months, and

(d) whether, if recoupment from other benefits is proposed, the length of time of extraordinary and lasting financial hardship shall be the longest potential period of benefit eligibility as seen at the time of the request for waiver of determination.

(5) In determining whether fraud has occurred, the department shall consider the following factors:

(a) whether the claimant knowingly made, or caused another to make, a false statement or representation of a material fact resulting in the overpayment;

(b) whether the claimant knowingly failed, or caused another to fail, to disclose a material fact resulting in the overpayment.

[**~~B.~~**] **(6)** If a determination of fraud is made, the claimant shall be ineligible for any further TAA, TRA or any other enacted federal extension program benefits and shall be ineligible for waiver of any overpayment.

[**~~C.~~**] **(7)** A finding that the TAA or TRA overpayment was not the result of a decision on appeal or that the recovery would not cause extraordinary and lasting financial hardship shall preclude a waiver.

[**~~D.~~**] **(8)** If a TAA or TRA claimant fails, without good cause, to complete training, a job search or a relocation, any TAA or TRA payment to such claimant that is not properly and necessarily expended in attempting to complete the activity shall constitute an overpayment. Such overpayments shall be recovered or waived according to the standards of fault, equity and good conscience contained in 11.3.300.325 NMAC.

B. Coronavirus Aid, Relief and Economic Security (CARES) Act overpayment waivers: The department shall use the process set forth in this subsection to evaluate disputes of overpayments paid under section 2105 of the CARES Act to specifically include Pandemic Unemployment Assistance (PUA) benefits, Federal Pandemic Unemployment Compensation (FPUC) benefits, Mixed Earners Unemployment Compensation (MEUC) benefits, and Pandemic Emergency Unemployment Compensation (PEUC) benefits:

(1) Claimants who were assessed an overpayment of CARES Act benefits are eligible to apply for a waiver of all or part of the federal benefit overpayment. A waiver will be approved if the department determines that:

(a) payment was made without the fault of the claimant; and

(b) requiring repayment would be contrary to equity and good conscience. Equity and good conscious, for the purposes of this subsection, exists when at least one of three circumstances exists: 1) recovery would cause financial hardship to the person from whom it is sought; 2) the recipient of the overpayment can show that due to the notice that such overpayment could be made or because of the

incorrect payment, either the claimant has relinquished a valuable right or changed positions for the worse; or 3) recovery would be unconscionable under the circumstances.

(2) Claimants seeking an overpayment waiver must affirmatively request an overpayment review. Waivers will be considered on an individual basis and shall not be granted as a matter of course unless a blanket waiver is specifically approved by the US department of labor.

(3) Claimants may file an application for a waiver of a federal CARES Act overpayment by completing the application in their online account or by contacting the department's operations center.

(4) The department's affirmative finding of any one of the following factors of fault precludes a waiver:

(a) that the claimant knowingly made a material misrepresentation, which misrepresentation resulted in the overpayment; or

(b) that the claimant knowingly failed to disclose a material fact, which failure to disclose resulted in the overpayment; or

(c) that the department has previously issued a determination of fraud in regards to the overpayment. Claimants may appeal the underlying fraud determination by following procedures outlined in 11.3.500 NMAC.

(5) After the waiver application has been adjudicated, a determination shall be issued informing the claimant of the outcome of the request, the overpayment amount waived, the reason any amount was not waived, and explaining the claimant's right to appeal the determination in accordance with 11.3.500 NMAC.

[~~D~~] **C.** In any event, no repayment shall be required or deduction made until a notice and an opportunity for fair hearing have been provided to the claimant in accordance with 11.3.500 NMAC, a determination has been issued by the department, and the determination has become final. Once a waiver application has been received by the department, all collections activity, including benefit offsets, collections notices, or liens shall cease until the waiver application has been processed and the decision is deemed final or all appeal deadlines under 11.3.500 NMAC or NMRA 1-077 have expired.

[11.3.300.325 NMAC - Rp, 11.3.300.325 NMAC, 11/1/2018 A, 10/29/2019; A, 11/19/2024]

End of Adopted Rules

2024 New Mexico Register

Submittal Deadlines and Publication Dates

Volume XXXV, Issues 1-24

Issue	Submittal Deadline	Publication Date
Issue 1	January 4	January 16
Issue 2	January 18	January 30
Issue 3	February 1	February 13
Issue 4	February 15	February 27
Issue 5	February 29	March 12
Issue 6	March 14	March 26
Issue 7	March 28	April 9
Issue 8	April 11	April 23
Issue 9	April 25	May 7
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Issue 20	October 10	October 22
Issue 21	October 24	November 5
Issue 22	November 7	November 19
Issue 23	November 26	December 10
Issue 24	December 12	December 23

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Issue 20	October 9	October 21
Issue 21	October 23	November 4
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