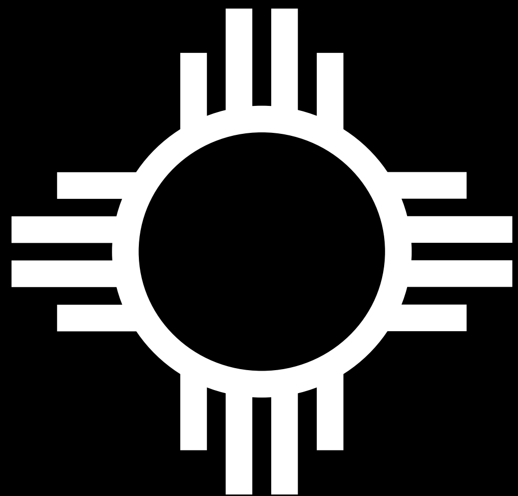
NEW MEXICO REGISTER



Volume XIX
Issue Number 14
July 31, 2008

New Mexico Register

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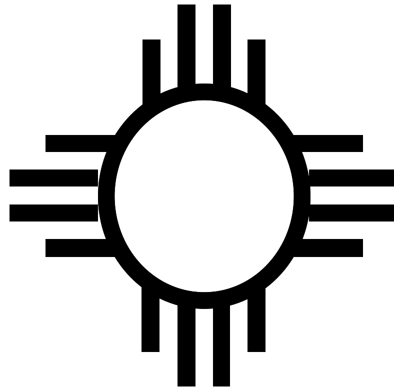

The official publication for all notices of rulemaking and filings of adopted, proposed and emergency rules in New Mexico

The Commission of Public Records
Administrative Law Division
Santa Fe, New Mexico
2008

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New Mexico Register

Volume XIX, Number 14
July 31, 2008

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Effective Date and Validity of Rule Filings

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

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The *New Mexico Register* is available free at **http://www.nmcpr.state.nm.us/nmregister**

The *New Mexico Register*
Published by
The Commission of Public Records
Administrative Law Division
1205 Camino Carlos Rey
Santa Fe, NM 87507

The *New Mexico Register* is published twice each month by the Commission of Public Records, Administrative Law Division. The cost of an annual subscription is $270.00. Individual copies of any Register issue may be purchased for $12.00. Subscription inquiries should be directed to: The Commission of Public Records, Administrative Law Division, 1205 Camino Carlos Rey, Santa Fe, NM 87507. Telephone: (505) 476-7907; Fax (505) 476-7910; E-mail staterules@state.nm.us.

Notices of Rulemaking and Proposed Rules

NEW MEXICO ENVIRONMENTAL IMPROVEMENT BOARD

NEW MEXICO ENVIRONMENTAL IMPROVEMENT BOARD
NOTICE OF PUBLIC MEETING AND RULEMAKING HEARING

The New Mexico Environmental Improvement Board ("Board") will hold a public hearing on October 6, 2008 at 10:00 a.m. at the State Capitol Building, Room 317, 490 Old Santa Fe Trail, Santa Fe NM 87501. The purpose of the hearing is to consider the matter of EIB 08-11 (R) proposed new rule to Air Quality Control Regulations 20.2.90 NMAC Field Citations.

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

NMED is proposing a new rule 20.2.90 NMAC Field Citations to implement a program to address minor violations of air quality regulations, including 20.2.60 NMAC - Open Burning and 20.2.65 NMAC - Smoke Management, and minor violations of permitted sources. The field citation program will be used as an alternative to conventional enforcement methods for minor violations.

The proposed new regulation may be reviewed during regular business hours at the NMED Air Quality Bureau office, 1301 Siler Road, Building B, Santa Fe, New Mexico 87507. A full text of NMED's revised regulations are available on NMED's web site at www.nmenv.state.nm.us, or by contacting Robert Spillers at (505) 476-4324 or robert.spillers@state.nm.us.

The hearing will be conducted in accordance with 20.1.1 NMAC (Rulemaking Procedures - Environmental Improvement Board), the Environmental Improvement Act, Section 74-1-9 NMSA 1978, the Air Quality Control Act Section, 74-2-6 NMSA 1978, and other applicable procedures.

All interested persons will be given reasonable opportunity at the hearing to submit relevant evidence, data, views and arguments, orally or in writing, to introduce exhibits, and to examine witnesses. Persons wishing to present technical testimony must file with the Board a written notice of intent to do so. The notice of intent shall:

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

Notices of intent for the hearing must be received in the Office of the Board not later than 5:00 pm on September 19, 2008, and should reference the docket number, EIB 08-11 (R), and the date of the hearing. Notices of intent to present technical testimony should be submitted to:

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

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

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

Persons having a disability and needing help in being a part of this hearing process should contact Judy Bentley by September 19, 2008 at the NMED, Personnel Services Bureau, P.O. Box 26110, 1190 St. Francis Drive, Santa Fe, New Mexico, 87502, telephone 505-827-9872. TDY users please access her number via the New Mexico Relay Network at 1-800-659-8331.

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

NEW MEXICO GAME COMMISSION

STATE GAME COMMISSION PUBLIC MEETING AND RULEMAKING NOTICE

On Thursday, August 21, 2008, beginning at 9:00 a.m., at the State Bar of New Mexico, 5121 Masthead, NE, Albuquerque, NM 87199, the State Game Commission will meet in Public Session to hear and consider action as appropriate on the following: Revocations; Fiscal Year 2008 4th Quarter and Annual Depredation Report; Approval of Fiscal Year 2010 Operating and Capital Project Budget Requests; Prospective 2009 Legislative Initiatives Update; General Public Comments (limited to 3 minutes); Update on Progress of Depredation Assistance Rule, 19.30.2, NMAC, Amendment Development Process; Update on Progress of Big Game Rule Development Process; Update on Antelope Harvest Management Review and Planning; Overview of Roswell Area Pronghorn Antelope and Deer Population Management Action Plan; Closed Executive Session to discuss litigation, personnel, acquisition or disposal of real property or water rights, and pursuant to §10-15-1(H)(1), NMSA, 1978, to discuss matters related to the determination of sending "Notice of Commission Contemplated Action" for outfitter and/or guide registration to any identified individual(s) that may have violated regulating procedures and conduct as per 19.30.8, and 19.31.2, NMAC; and Notice of Commission Contemplated Action.

The following rules will be opened for public comment and consideration for adoption by the Commission:

* Biennial Review of New Mexico State-listed Wildlife (19.33.3, NMAC); and
* Adoption of Amendments to the New Mexico Hunter-Trapper Harvest Reporting Rule, 19.30.10, NMAC.

A copy of the agenda or any of the affected rules can be obtained from the Office of the Director, New Mexico Department of Game and Fish, P.O. Box 25112, Santa Fe, New Mexico 87504 or on the Department's website. This agenda is subject to change up to 24 hours prior to the meeting. Please contact the Director's Office at (505) 476-8008, or the Department's website at www.wildlife.state.nm.us for updated information.

If you are an individual with a disability who is in need of a reader, amplifier, quali-

fied sign language interpreter, or any other form of auxiliary aid or service to attend or participate in the hearing or meeting, please contact Shirley Baker at (505) 476-8029. Please contact Ms. Baker at least 3 working days before the set meeting date. Public documents, including the Agenda and Minutes can be provided in various accessible forms. Please contact Shirley Baker if a summary or other type of accessible form is needed.

NEW MEXICO DEPARTMENT OF HEALTH

NOTICE OF PUBLIC HEARING

The New Mexico Department of Health will hold a public hearing on 7.34.4 NMAC "Licensing Requirements For Producers, Production Facilities and Distribution" and 7.34.3 NMAC "Registration Identification Cards". The Hearing will be held on Monday, September 8, 2008 at 9:00 a.m. in the Harold Runnels Building Auditorium, located at 1190 St. Francis Drive, Santa Fe, New Mexico.

The public hearing will be conducted to establish rules for a regulated system of medical use cannabis by issuing identification cards for participating individuals, developing a distribution system by licensure of medical use cannabis producers and production facilities.

A copy of the proposed rules can be obtained from:

Melissa Milam
1190 St. Francis Dr. Suite S1202
Santa Fe, NM 87502
(505) 827-2321

Please submit any written comments regarding the proposed rules to:

Melissa Milam
1190 St. Francis Dr. Suite S1202
Santa Fe, NM 87502
(505) 827-2321

The Department will accept public comment through the close of the hearing.

If you are an individual with a disability who is in need of special services to attend or participate in the hearing, please contact Melissa Milam by telephone at (505) 827-2321. The Department requests at least ten (10) days advance notice to provide requested special accommodations.

NEW MEXICO STATE PERSONNEL BOARD

State Personnel Board Public Rules Hearing

The State Personnel Board will convene a Public Rules Hearing in Santa Fe, New Mexico on September 22, 2008. The hearing will be held during the Board's regular business meeting beginning at 9:00 a.m., located in Farmington, with the specific site location to be determined.

The purpose of the Rule Hearing is to consider amending SPB Rules and Regulations related to 1.7.1 NMAC, General Provisions; 1.7.2 NMAC Classified Service Appointments; 1.7.3 NMAC Classifications; 1.7.4 NMAC Pay; 1.7.6 NMAC General Working Conditions; 1.7.7 NMAC Absence and Leave; 1.7.8 NMAC Drug and Alcohol Abuse; 1.7.10 NMAC Furlough, Reduction in Force, Reemployment, Separation Without Prejudice; 1.7.11 NMAC Discipline; and 1.7.12 NMAC Adjudication.

A final agenda for the board meeting will be available at the board office on September 12, 2008.

Persons desiring to present their views on the proposed amendments may appear in person at said time and place or may submit written comments no later than 5:00 p.m. September 2, 2008 to the board office, PO Box 26127, 2600 Cerrillos Road, Santa Fe, New Mexico, 87505, attention, Ken Giles. Copies of the proposed rules are available on request from the Board office at the address listed above, by phone (505) 476-7805, or on the Internet at www.state.nm.us/spo/ beginning July 31, 2008.

If you are an individual with a disability who is in need of a reader, amplifier, qualified sign language interpreter, or any other form of auxiliary aid or service in order to attend or participate in the hearing, please contact the Director at 2600 Cerrillos Road, Santa Fe, New Mexico prior to the meeting. Public documents, including the agenda and minutes can be provided in various accessible formats. Please contact the Director if a summary or other type of accessible format is needed.

NEW MEXICO PUBLIC EDUCATION DEPARTMENT

NEW MEXICO PUBLIC EDUCATION DEPARTMENT

The Public Education Department ("Department") hereby gives notice that the Department will conduct a public hearing at Mabry Hall, Jerry Apodaca Education Building, 300 Don Gaspar, Santa Fe, New Mexico, 87501-2786, on September 3, 2008, from 1:30 p.m. to 3:30 p.m. The purpose of the public hearing will be to obtain input on the following rule:

Rule Number	Rule Name	Proposed Action
6.30.8 NMAC	Distance Learning	Repeal and replace rule to clarify requirements for implementation of distance learning courses and integrate provisions of 22 -30-1 et seq. NMSA 1978.

Interested individuals may testify either at the public hearing or submit written comments regarding the proposed rulemaking to Ms. Noreen Romero, IDEAL-NM, 5201 Eagle Rock, Suite 2A, Albuquerque, NM 87113 (noreen.romero@state.nm.us) 505-383-2401, telefax 505-383-2449.

Written comments must be received no later than 5:00 pm on September 3, 2008. However, the submission of written comments as soon as possible is encouraged.

The proposed rulemaking actions may be accessed on the Department's website (http://ped.state.nm.us/) or obtained from Ms. Noreen Romero, IDEAL-NM, 5201 Eagle Rock, Suite 2A, Albuquerque, NM 87113 (noreen.romero@state.nm.us) 505-383-2401, telefax 505-383-2449. The proposed rules will be made available at least thirty days prior to the hearings.

Individuals with disabilities who require this information in an alternative format or need any form of auxiliary aid to attend or participate in this meeting are asked to contact Ms. Romero as soon as possible. The Department requests at least ten (10) days advance notice to provide requested special accommodations.

NEW MEXICO REGULATION AND LICENSING DEPARTMENT

CONSTRUCTION INDUSTRIES DIVISION

**STATE OF NEW MEXICO
CONSTRUCTION INDUSTRIES DIVISION
of the
Regulation and Licensing Department**

NOTICE OF PUBLIC HEARING

A Public Hearing on proposed amendments to 14.5.1 NMAC, Sections 7 and 9 – General Provisions, and adoption of the 2006 New Mexico Swimming Pool, Spa and Hot Tub Code will be held on **THURSDAY, August 28, 2008, FROM 9:00 A.M. TO 12:00 NOON**, at the following locations:

* **ALBUQUERQUE, NM** – CID Conference Room: 5200 Oakland Avenue, NE
* **SANTA FE, NM** - CID Conference Room, 2550 Cerrillos Road, 3rd Floor, Santa Fe

Copies of the draft rule will be available at the Construction Industries Division offices beginning August 15, 2008.

You are invited to attend and express your opinion on these proposed rules changes. If you cannot attend the meeting, you may send your written comments to the Construction Industries Division, 2550 Cerrillos Road, P.O. Box 25101, Santa Fe, New Mexico 87504, Attention: Public Comments. FAX (505) 476-4685. All comments must be received no later than 5:00 p.m., August 28, 2008.

If you require special accommodations to attend the hearing, please notify the Division by phone, email or fax, of such needs no later than August 15, 2008. Telephone: 505-476-4700. Email: www.rld@state.nm.us/cid Fax No. 505-476-4685.

End of Notices and Proposed Rules Section

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Adopted Rules

NEW MEXICO DEPARTMENT OF AGRICULTURE

This is an amendment to 21.26.2 NMAC, Sections 1 and 8, effective August 1, 2008. This rule was also reformatted and renumbered to comply with current NMAC requirements.

21.26.2.1 ISSUING AGENCY: [~~Nick Carson, Chairman, New Mexico Chile Commission, P. O. Box 101, Rincon NM 87940-0101, Telephone (505) 267-4790~~] Dave Layton, Chairman, New Mexico Chile Commission, 4065 J Street, SE, Deming, NM 88030, Telephone (575) 546-8863.
[9/15/97; 21.26.2.1 NMAC - Rn & A, 21 NMAC 26.2.1, 08/01/08]

21.26.2.8 ASSESSMENT:
A. The commission assessment rate is set at [~~fifty cents ($.50)~~] $.625 per ton of fresh chile peppers and [~~one dollar ($1)~~] $1.25 per ton of dry chile peppers.
B. The first handler shall deduct the assessment from the amount paid to the producer.
C. The first handler shall make payment of the assessment to the New Mexico chile commission. Payment dates for fresh chile peppers shall be prior to December 1. Payment dates for dry chile peppers shall be prior to April 1.
D. Producers may obtain assessment refunds by making an application to the commission. Application shall be made on forms approved by the commission within thirty (30) days after the sale of assessed chile. The commission shall make refunds within thirty (30) days of the date the application is received, unless the proceeds and the necessary information have not been received by the commission, in which case the refund will be made within fifteen (15) days after receipt of the proceeds and necessary information.
[9/15/97; 21.26.2.8 NMAC - Rn & A, 21 NMAC 26.2.8, 08/01/08]

ALBUQUERQUE-BERNALILLO COUNTY AIR QUALITY CONTROL BOARD

TITLE 20 ENVIRONMENTAL PROTECTION
CHAPTER 11 ALBUQUERQUE-BERNALILLO COUNTY AIR QUALITY CONTROL BOARD
PART 82 RULEMAKING PROCEDURES — AIR QUALITY CONTROL BOARD

20.11.82.1 ISSUING AGENCY: Albuquerque-Bernalillo County Air Quality Control Board, c/o Environmental Health Department. P.O. Box 1293, Albuquerque, New Mexico 87103. Telephone: (505) 768-2601.
[20.11.82.1 NMAC - N, 8/11/08]

20.11.82.2 SCOPE: 20.11.82 NMAC governs the procedures in all rulemaking hearings before the board, except to the extent that 20.11.82 NMAC is inconsistent with specific procedures in governing law. In cases in which 20.11.82 NMAC is inconsistent with any rulemaking procedures specified in governing law, the procedures in governing law shall apply, rather than the procedures in 20.11.82 NMAC. A rulemaking hearing includes a hearing regarding a proposal to adopt, amend or repeal a board rule, regulation or standard.
[20.11.82.2 NMAC - N, 8/11/08]

20.11.82.3 STATUTORY AUTHORITY: 20.11.82 NMAC is adopted pursuant to the authority provided in the New Mexico Air Quality Control Act, NMSA 1978 Sections 74-2-4, 74-2-5; the Joint Air Quality Control Board Ordinance, Bernalillo County Ordinance No. 94-5, Sections 4 and 5; and the Joint Air Quality Control Board Ordinance, Revised Ordinances of Albuquerque 1994, Sections 9-5-1-4 and 9-5-1-5.
[20.11.82.3 NMAC - N, 8/11/08]

20.11.82.4 DURATION: Permanent.
[20.11.82.4 NMAC - N, 8/11/08]

20.11.82.5 EFFECTIVE DATE: August 11, 2008, unless a later date is cited at the end of a section.
[20.11.82.5 NMAC - N, 8/11/08]

20.11.82.6 OBJECTIVE: The purposes of 20.11.82 NMAC are to:
A. standardize the procedures used in rulemaking proceedings before the board;
B. encourage participation in the hearings conducted by the board for the promulgation of regulations;
C. make possible the effective presentation of the evidence and points of view of parties and members of the general public; and
D. assure that board hearings are conducted in a fair and equitable manner.
[20.11.82.6 NMAC - N, 8/11/08]

20.11.82.7 DEFINITIONS: As used in 20.11.82 NMAC:
A. "Act" means the Air Quality Control Act, Chapter 74, Article 2 NMSA 1978, and its later amendments and successor provisions.
B. "Board" means Albuquerque-Bernalillo county air quality control board or its successor board pursuant to the act.
C. "Days" means consecutive days except as otherwise specifically provided.
D. "Department" means the city of Albuquerque environmental health department or its successor agency.
E. "Document" means any paper, exhibit, pleading, motion, response, memorandum, decision, order or other written or tangible item that is filed in a proceeding pursuant to 20.11.82 NMAC, or brought to or before the board for its consideration, but does not include a cover letter accompanying a document transmitted for filing.
F. "Environmental justice" means the fair treatment of all residents (in the City of Albuquerque and Bernalillo County), including communities of color and low income communities, and their meaningful involvement in the development, implementation and enforcement of environmental laws, regulations and policies regardless of race, color, ethnicity, religion, income or education level.
G. "Exhibit" means any document or tangible item submitted for inclusion in the hearing record.
H. "Ex parte contact" means oral or other communication with a board member or a board hearing officer regarding the merits of a pending rulemaking procedure if:
(1) the communication is made by a person who is not a board member, hearing clerk or hearing officer;
(2) the person communicating knows or has reason to know a petition has been filed pursuant to 20.11.82 NMAC;
(3) the communication is made without all other parties being present or receiving the same communication that was received by the board member or the board hearing officer; and
(4) the communication is intended to affect, or reasonably may be expected to affect the board member's or the hearing officer's opinion regarding the merits of the pending rulemaking proceeding.
I. "General public" means any person attending a rulemaking hearing who has not submitted a notice of

intent to present technical testimony or filed an entry of appearance pursuant to 20.11.82.20 NMAC or 20.11.82.21 NMAC.

J. "Governing law" means the statute, including any applicable case law, which authorizes and governs the decision regarding the proposed regulatory change.

K. "Hearing clerk" means the department employee designated by the director to provide staff support to the board, and is the person designated by the board to maintain the official record of the proceeding.

L. "Hearing officer" means the person who is designated by the board to conduct a hearing pursuant to 20.11.82 NMAC.

M. "Hearing record" means:

(1) the transcript of proceedings; and

(2) the record proper.

N. "Party" means the petitioner, any person filing a notice of intent to present technical testimony, and any person filing an entry of appearance pursuant to 20.11.82.20 NMAC or 20.11.82.21 NMAC.

O. "Non-technical testimony" means testimony that is not scientific, engineering, economic or other specialized testimony. A person who provides only non-technical testimony or a non-technical exhibit is not required to file an NOI or entry of appearance pursuant to 20.11.82.20 NMAC or 20.11.82.21 NMAC.

P. "Participant" means any person who participates in a rulemaking proceeding before the board.

Q. "Person" means an individual or any entity, including federal, state and local governmental entities, however organized.

R. "Petitioner" means the person who petitioned the board for the regulatory change that is the subject of the hearing.

S. "Record proper" or **"record"** means all documents related to the hearing, including documents received or generated by the board before the beginning, or after the conclusion of the hearing, including, but not limited to:

(1) the petition for hearing and any response thereto;

(2) the minutes (or an appropriate extract of the minutes) of the meeting at which the petition for hearing was considered, and of any meeting thereafter at which the proposed regulatory change was discussed;

(3) the notice of hearing;

(4) proof of publication;

(5) notices of intent to present technical testimony;

(6) statements for the public record;

(7) the hearing officer's report, if any;

(8) post-hearing submissions, if allowed;

(9) the stenographic transcription or audio tape of the hearing and the stenographic transcription or audio tapes or appropriate extract of the audio tapes of the meeting at which the board deliberated on the adoption of the proposed regulatory change; and

(10) the board's decision and the reasons therefore.

T. "Regulation" means a rule, regulation or standard promulgated by the board that affects one or more persons, in addition to the board and the department, except for any order or decision issued in connection with the disposition of any case involving a particular matter as applied to a specific set of facts.

U. "Regulatory change" means the adoption, amendment or repeal of a regulation.

V. "Service" means personally delivering a copy of a document, exhibit or pleading to a party required by 20.11.82 NMAC to be served; mailing it to that person; or, if that person has agreed in writing, sending it by facsimile or electronic transmission. If a person is represented by an attorney, service shall be made on the attorney. Service by mail is complete upon mailing the document unless service is made by mail to a party who must act within a prescribed period after being served, in which case three days shall be added to the prescribed period. The three-day extension does not apply to any deadline imposed by the act. Service by facsimile or electronic transmission is accomplished when the transmission of the document is complete. The person who receives the facsimile or electronic transmission shall promptly provide written confirmation of receipt if requested by the hearing officer, the board or a party.

W. "Technical testimony" means scientific, engineering, economic or other specialized testimony, but does not include legal argument, general comments, or statements of policy or position concerning matters at issue in the hearing.

X. "Transcript of proceedings" means the verbatim record, audio tape or stenographic transcription of the proceedings, testimony and argument in the matter, together with all exhibits offered at the hearing, whether or not admitted into evidence, and includes the record of any motion hearings or pre-hearing conferences.
[20.11.82.7 NMAC - N, 8/11/08]

20.11.82.8 VARIANCES: The variance procedures provided by 20.11.7 NMAC shall not apply to 20.11.82 NMAC.
[20.11.82.8 NMAC - N, 8/11/08]

20.11.82.9 SEVERABILITY: If for any reason any section, subsection, sentence, phrase, clause, wording or application of 20.11.82 NMAC is held to be unconstitutional or otherwise invalid by any court or the United States environmental protection agency, the decision shall not affect the validity or application of remaining portions of 20.11.82 NMAC.
[20.11.82.9 NMAC - N, 8/11/08]

20.11.82.10 DOCUMENTS: Documents incorporated and cited in 20.11.82 NMAC may be viewed at the Albuquerque environmental health department, 400 Marquette NW, Room 3023, Albuquerque, NM 87102.
[20.11.82.10 NMAC - N, 8/11/08]

20.11.82.11 POWERS AND DUTIES OF BOARD AND HEARING OFFICER:

A. Board: The board shall exercise all powers and duties authorized by 20.11.82 NMAC and not otherwise delegated to the hearing officer or the hearing clerk.

B. Hearing officer: The board shall designate a hearing officer for each hearing. The hearing officer shall exercise all powers and duties delegated or otherwise authorized by 20.11.82 NMAC. The hearing officer may be a member of the board. The hearing officer shall conduct a fair and impartial proceeding, assure that the facts are fully elicited and avoid delay. The hearing officer shall have authority to take all measures necessary for the maintenance of order and for the efficient, fair and impartial consideration of issues arising in proceedings governed by 20.11.82 NMAC, including:

(1) conducting hearings pursuant to 20.11.82 NMAC;

(2) taking, admitting or excluding evidence, examining witnesses and allowing post-hearing submissions;

(3) making orders as may be necessary to preserve decorum and to protect the orderly hearing process;

(4) if requested by the board, preparing and filing a report of the hearing, with recommendations for board action;

(5) requesting parties to file original documents with the hearing clerk;

(6) establishing the deadlines for filing documents with the hearing clerk; and

(7) requesting the prevailing party to submit a proposed statement of reasons in support of the board's decision.

C. Notice of hearing officer assignment: If a hearing officer other than a board member is assigned as a hearing officer, the hearing clerk shall notify the parties of the name and address of the hear-

ing officer. At the same time, the hearing clerk also shall forward to the hearing officer copies of all documents related to the petition that have been filed to date.
[20.11.82.11 NMAC - N, 8/11/08]

20.11.82.12 LIBERAL CONSTRUCTION: 20.11.82 NMAC shall be liberally construed to carry out its objectives.
[20.11.82.12 NMAC - N, 8/11/08]

20.11.82.13 GENERAL PROVISIONS - COMPUTATION OF TIME:

A. Computation of time: In computing any period of time prescribed or allowed by 20.11.82 NMAC, except as otherwise specifically provided, the day of the event from which the designated period begins to run shall not be included. The last day of the computed period shall be included, unless it is a Saturday, Sunday, or legal city of Albuquerque holiday, in which event the time shall be extended until the end of the next day that is not a Saturday, Sunday or legal city of Albuquerque holiday. Whenever a party must act within a prescribed period after service upon a party, and service is by mail, three days shall be added to the prescribed period. The three-day extension does not apply to any deadline imposed by the act.

B. Extension of time: For good cause shown, and after consideration of prejudice to other parties, the board or hearing officer may grant an extension of time for filing any document upon timely motion of a party to the proceeding.
[20.11.82.13 NMAC - N, 8/11/08]

20.11.82.14 GENERAL PROVISIONS - RECUSAL:

A. No board member shall participate in any action in which his or her impartiality or fairness may reasonably be questioned, and the member shall recuse himself or herself in any such action by giving notice to the board and the general public by announcing the recusal on the record. In making a decision to recuse him or herself, the board member may rely upon any relevant authority.

B. A board member or a hearing officer shall not perform any function authorized by 20.11.82 NMAC regarding any matter in which a board member or a hearing officer:

(1) has a personal bias or prejudice concerning a party;

(2) is related to a party within the third degree of relationship;

(3) is an officer, director or trustee of a party or interested participant in the proceeding; or

(4) has a financial interest in the proceeding or has any other conflict of interest.
[20.11.82.14 NMAC - N, 8/11/08]

20.11.82.15 GENERAL PROVISIONS - EX PARTE COMMUNICATION: At no time after a proceeding is initiated by filing a petition pursuant to 20.11.82.18 NMAC and before the conclusion of a proceeding initiated pursuant to 20.11.82 NMAC shall the department, or any other party, interested participant or their representatives communicate ex parte, orally or in writing, with any board member or the hearing officer, regarding the merits of the proceeding.
[20.11.82.15 NMAC - N, 8/11/08]

20.11.82.16 DOCUMENT REQUIREMENTS - FILING AND SERVICE OF DOCUMENTS:

A. The filing of any document as required by 20.11.82 NMAC shall be accomplished by delivering the document to the hearing clerk.

B. Any person filing any document shall:

(1) provide the hearing clerk with the original and nine copies of the document, unless the document is an exhibit, in which case 20.11.82.27 NMAC shall apply;

(2) deliver a copy to the board attorney;

(3) serve a copy thereof on the petitioner, if the document is a notice of intent to present technical testimony filed by any person other than the petitioner; and

(4) file with the hearing clerk at least 15 days before any meeting at which the board will consider the document. If the document is a motion seeking an order from the hearing officer in a rulemaking hearing, the motion shall also be served at the same time on the hearing officer and the board attorney. Motions and responses shall be filed only by parties to a hearing and shall comply with 20.11.82.16 NMAC.

C. Whenever 20.11.82 NMAC requires service of a document, service on all other parties shall be made by delivering a copy to the person to be served by mailing it, or, if that person has agreed in writing, by sending it by facsimile or by electronic transmission to that person. An agreement to be served by facsimile or electronic transmission may be evidenced by placing the person's facsimile number or email address on a document filed pursuant to 20.11.82 NMAC. Service shall also be made upon the board's attorney. If a person is represented by an attorney, service of the document shall be made on the attorney. Service by mail is complete upon mailing the document unless service is made by mail to a party who must act within a prescribed period after being served, in which case three days shall be added to the prescribed period. The three-day extension does not apply to any deadline imposed by the act. Service by facsimile or electronic transmission is accomplished when the transmission of the document is completed. The person who received the facsimile or electronic transmission shall promptly provide written confirmation of receipt if requested by the hearing officer, the board or a party.

D. The petitioner and any person who has filed a timely notice of intent to present technical testimony pursuant to 20.11.82.20 NMAC may inspect all documents that have been filed in a proceeding in which he or she is involved as a participant. The inspection shall be permitted as provided by the Inspection of Public Records Act, NMSA 1978, Sections 14-2-1 through 14-2-12. Whenever any document is filed in a proceeding subject to 20.11.82 NMAC, the hearing clerk shall notify by email the petitioner and all persons who have filed a timely notice of intent to present technical testimony. A person who does not provide an email address shall instead be notified by mail.

E. All documents filed pursuant to 20.11.82 NMAC shall be made available for inspection upon request as provided by the Inspection of Public Records Act, NMSA 1978, Sections 14-2-1 through 14-2-12.

F. The hearing clerk shall provide copies of all documents to each board member at least five days before a hearing or meeting at which the board will consider the documents. With regard to documents filed in conjunction with any rulemaking hearing, the hearing officer may make an exception to this requirement.

G. 20.11.82.20 NMAC and 20.11.82.27 NMAC also provide requirements regarding hearing exhibits.
[20.11.82.16 NMAC - N, 8/11/08]

20.11.82.17 EXAMINATION OF DOCUMENTS FILED:

A. Examination allowed: Subject to the provisions of law restricting the public disclosure of confidential information, during normal business hours any person may inspect and request a copy of any document filed in any rulemaking proceeding before the board. The documents shall be made available by the hearing clerk as required by the Inspection of Public Records Act, NMSA 1978, Sections 14-2-1 through 14-2-12, and may be viewed at the Albuquerque environmental health department, 400 Marquette NW, Room 3023, Albuquerque, NM 87102.

B. Cost of duplication: The cost of duplicating documents shall be borne by the person seeking copies of the documents.

[20.11.82.17 NMAC - N, 8/11/08]

20.11.82.18 PREHEARING PROCEDURES - PETITION FOR REGULATORY CHANGE:

A. Any person may file a petition with the board to adopt, amend or repeal any regulation within the jurisdiction of the board.

B. The petition shall be in writing and shall include a statement of the reasons for the proposed regulatory change. The petition shall cite the relevant statutes that authorize the board to adopt the proposed regulatory change, and shall estimate the time that will be needed to conduct the rulemaking hearing, if at all possible. A copy of the entire rule, including any proposed regulatory change, indicating any language proposed to be added or deleted, shall be attached to the petition. The entire rule and its proposed changes shall be submitted to the board in legislative-edit format, with strike-outs and underlines as appropriate, and shall include individual line numbers. The hearing clerk shall return to the petitioner any document that does not meet the requirements of 20.11.82.18 NMAC, along with a copy of 20.11.82 NMAC and a check-list of required items. The petitioner will be asked to resubmit the petition as required by 20.11.82.18 NMAC.

C. At a public meeting occurring no later than 60 days after receipt of the petition, the board shall determine whether or not to hold a public hearing on the proposal. Any person may respond to the petition either in writing before the public meeting or in person at the public meeting.

D. If the board decides to hold a public hearing on the petition, the board may issue orders specifying procedures for conduct of the hearing, in addition to the requirements established in 20.11.82 NMAC, as may be necessary and appropriate to fully inform the board of the matters at issue in the hearing or control the conduct of the hearing. The orders may include requirements for giving additional public notice, holding pre-hearing conferences, filing direct testimony in writing before the hearing, or limiting testimony or cross-examination.

[20.11.82.18 NMAC - N, 8/11/08]

20.11.82.19 NOTICE OF HEARINGS:

A. Unless otherwise allowed by governing law and specified by the board, the board, through the hearing clerk, shall give public notice of the hearing at least 30 days before the hearing unless the board requires a longer public notice period. Public notice shall include at a minimum:

(1) a single publication in the newspaper with the largest general circulation in Bernalillo county;

(2) publication in the New Mexico Register;

(3) if technically feasible at the time, publication by electronic media; and

(4) other means of providing notice as the board may direct or are required by law.

B. The board shall make reasonable efforts to give notice to persons who have made a written request to the board for advance notice of regulatory change hearings. Requests for notice shall be addressed to hearing clerk and shall designate the areas of board activity that are of interest.

C. Public notice of the hearing shall state:

(1) the subject, including a description of the proposed regulatory change, date, time and place of the hearing;

(2) the statutes, regulations and procedural rules governing the conduct of the hearing;

(3) the manner in which persons may present their views or evidence to the board;

(4) the location where persons may obtain copies of the proposed regulatory change; and

(5) if applicable, that the board may make a decision on the proposed regulatory change at the conclusion of the hearing or at a separate board meeting.

[20.11.82.19 NMAC - N, 8/11/08]

20.11.82.20 TECHNICAL TESTIMONY; NOTICE OF INTENT (NOI):

A. No later than 15 days before the hearing, any person, including the petitioner, who intends to present technical testimony at the hearing shall file a notice of intent to present technical testimony. The notice shall:

(1) identify the person for whom the witness or witnesses will testify;

(2) identify each technical witness the person intends to present and state the qualifications of that witness, including a description of their educational and work background;

(3) summarize or include a copy of the direct testimony of each technical witness and state the anticipated duration of the testimony of that witness;

(4) include the text of any recommended modifications to the proposed regulatory change; and

(5) list and describe, or attach, all exhibits anticipated to be offered by that person at the hearing, including any proposed statement of reasons for adoption of rules.

B. The person filing an NOI shall serve the notice pursuant to 20.11.82.16 NMAC.

C. The hearing officer may enforce the provisions of 20.11.82.20 NMAC by taking whatever action the hearing officer deems appropriate, including exclusion of the technical testimony of any witness for whom a notice of intent was not timely filed. If the testimony is admitted, the hearing officer may keep the record open after the hearing to allow responses to the testimony.

[20.11.82.20 NMAC - N, 8/11/08]

20.11.82.21 ENTRY OF APPEARANCE: Any person who is or may be affected by the proposed regulatory change may file an entry of appearance and shall be a party. The entry of appearance shall be filed no later than 15 days before the date of the hearing on the petition.

[20.11.82.21 NMAC - N, 8/11/08]

20.11.82.22 PARTICIPATION BY GENERAL PUBLIC:

A. Any member of the general public may testify at the hearing. Notification before the hearing is not required in order to present non-technical testimony at the hearing. A person providing non-technical testimony also may offer non-technical exhibits in connection with the testimony provided, if the exhibit is not unduly repetitious of the testimony provided. The board requests but does not require members of the general public to provide the hearing clerk with an original and nine copies of every non-technical exhibit before or at the hearing.

B. A member of the general public who wishes to submit a non-technical written statement for the record instead of providing oral testimony at the hearing shall file the written statement before the hearing or submit it at the hearing.

[20.11.82.22 NMAC - N, 8/11/08]

20.11.82.23 LOCATION OF HEARING: Unless otherwise provided by governing law, the board shall hold rulemaking hearings and meetings in public facilities within Bernalillo county with public seating available.

[20.11.82.23 NMAC - N, 8/11/08]

20.11.82.24 PARTICIPATION AT A BOARD MEETING BY CONFERENCE TELEPHONE OR OTHER SIMILAR DEVICE: A member of the board may participate in a meeting of the board by means of a conference telephone or other similar communications equipment when a medical or emergency situation exists that makes it extremely difficult or impossible for the member to attend the meeting in person, provided that each member participating by conference telephone or other device can be identified when speaking, all partici-

pants are able to hear each other at the same time, and members of the public attending the meeting are able to hear any member of the board who speaks at the meeting. A request to be present and vote by telephone or other similar device shall be made by the member to the chair or acting chair of the board by the member. A board member who wishes to participate in a meeting in this manner must receive permission from the chair or acting chair of the board sufficiently in advance of the meeting so the hearing clerk can arrange for an adequate telephone hookup. The chair or acting chair shall determine whether a qualifying medical or emergency situation exists. A board member's participation by such means shall constitute presence in person at the meeting. This provision shall not be used to allow a member to constitute a quorum of the board, and may only be used for the purposes of:

A. choosing a hearing officer;

B. authorizing the hearing clerk to secure a hearing officer for a hearing or hearings;

C. scheduling or rescheduling a meeting or hearing; and

D. voting on the limited issues listed in Subsections A, B, and C of 20.11.82.24 NMAC.

[20.11.82.24 NMAC - N, 8/11/08]

20.11.82.25 HEARING PROCEDURES - CONDUCT OF HEARINGS:

A. The rules of civil procedure and the rules of evidence shall not apply.

B. The hearing officer shall conduct the hearing in a manner that provides a reasonable opportunity for all persons to be heard without making the hearing unreasonably lengthy or cumbersome, or burdening the record with unnecessary repetition. The hearing shall proceed as follows.

(1) The hearing shall begin with an opening statement from the hearing officer. The statement shall identify the nature and subject matter of the hearing and explain the procedures to be followed.

(2) The hearing officer may allow a brief opening statement by any person who wishes to make one.

(3) Unless otherwise ordered, the petitioner shall present its case first.

(4) The hearing officer shall establish an order for the testimony of other participants. The order may be based upon notices of intent to present technical testimony, sign-in sheets and the availability of witnesses who cannot be present for the entire hearing.

(5) If the hearing continues for more than one day, the hearing officer shall provide an opportunity each day for testimony from members of the general public. Members of the general public who wish to present testimony should indicate their intent to testify on a sign-in sheet.

(6) The hearing officer may allow a brief closing argument by any person who wishes to make one.

(7) At the close of the hearing, the hearing officer shall determine whether to keep the record open for written submittals in accordance 20.11.82.29 NMAC. If the record is kept open, the hearing officer shall determine and announce the subject or subjects regarding which submittals will be allowed and the deadline for filing the submittals.

[20.11.82.25 NMAC - N, 8/11/08]

20.11.82.26 TESTIMONY AND CROSS-EXAMINATION:

A. All testimony shall be taken under oath or affirmation, which may be accomplished as a group or individually.

B. The hearing officer shall admit all relevant evidence, unless the hearing officer determines that the evidence is incompetent or unduly repetitious. The hearing officer shall require all oral testimony be limited to the position of the witness in favor of or against the proposed rule.

C. Any person who testifies at the hearing is subject to cross-examination on the subject matter of his or her direct testimony and matters affecting his or her credibility. Any person attending the hearing is entitled to conduct cross-examination as may be required for a full and true disclosure of matters at issue in the hearing. The hearing officer may limit cross-examination to avoid harassment, intimidation, needless expenditure of time or undue repetition.

[20.11.82.26 NMAC - N, 8/11/08]

20.11.82.27 TECHNICAL EXHIBITS:

A. The deadlines for filing technical exhibits are established by 20.11.82.20 NMAC.

B. Any person offering a technical exhibit shall provide the hearing clerk with an original and 15 copies for the board, the hearing officer, the board attorney, and persons attending the hearing.

C. All exhibits offered at the hearing shall be marked with a designation identifying the person offering the exhibit and shall be numbered sequentially. If a person offers multiple exhibits, the person shall identify each exhibit with an index tab or by other appropriate means.

D. Large charts and diagrams, models and other bulky exhibits are discouraged. If visual aids are used, legible copies shall be submitted for inclusion in the record.

[20.11.82.27 NMAC - N, 8/11/08]

20.11.82.28 TRANSCRIPT OF PROCEEDINGS: The hearing clerk shall arrange for a court reporter to make a verbatim transcription of the hearing unless the board requires another method of recording. The petitioner shall pay the cost of the court reporter and the original transcription. The petitioner shall also pay the cost of a copy of a transcription for each board member, the hearing officer and the board attorney if required by the hearing officer or the board.

[20.11.82.28 NMAC - N, 8/11/08]

20.11.82.29 POST-HEARING SUBMISSIONS: The hearing officer may allow the record to remain open for a reasonable period of time following the conclusion of the hearing for written submission of additional evidence, comments and arguments, and proposed statements of reasons. The hearing officer's determination shall be announced at the conclusion of the hearing. In considering whether the record will remain open, the hearing officer shall consider the reasons why the material was not presented during the hearing, the significance of the material to be submitted and the necessity for a prompt decision.

[20.11.82.29 NMAC - N, 8/11/08]

20.11.82.30 HEARING OFFICER'S REPORT: If the board directs, the hearing officer shall file a report of the hearing. The report shall identify the issues addressed at the hearing, explain the testimony and make a recommendation for board action, and shall be filed with the hearing clerk within the time specified by the board. The hearing clerk shall promptly notify each participant that the hearing officer's report has been filed and shall provide a copy of the report upon request as required by 20.11.82.17 NMAC.

[20.11.82.30 NMAC - N, 8/11/08]

20.11.82.31 DELIBERATION AND DECISION:

A. As provided in the act at NMSA 74-2-5.E, in making its regulations, the board shall give weight it deems appropriate to all facts and circumstances, including:

(1) character and degree of injury to or interference with health, welfare, visibility and property;

(2) the public interest, including the social and economic value of the sources and subjects of air contaminants with due consideration for environmental justice principles; and

(3) technical practicability and economic reasonableness of reducing or eliminating air contaminants from the

sources involved and previous experience with equipment and methods available to control the air contaminants involved.

B. If a quorum of the board attended the hearing, and if the hearing notice indicated that a decision might be made at the conclusion of the hearing, the board may immediately deliberate and make a decision on the proposed regulatory change at the end of the hearing or at a board meeting after the hearing.

C. If the board does not reach a decision at the conclusion of the hearing, then, following receipt of the transcript, the hearing clerk shall promptly furnish a copy of the transcript to each board member who did not attend the hearing and, if necessary, to other board members, board attorney and the hearing officer. Exhibits that were provided to persons at the time of the hearing need not be supplied again.

D. The board shall reach its decision on the proposed regulatory change within 60 days after the later of the close of the record or the date the hearing officer's report is filed, if a quorum of the board is available.

E. During the course of its deliberations, if the board determines that additional testimony or documentary evidence is necessary for a proper decision on the proposed regulatory change, then, consistent with the requirements of due process, the board may reopen the hearing for necessary additional evidence only. The board or hearing officer may require additional notice as appropriate.

F. The board shall issue its decision on the proposed regulatory change in a suitable format, which shall include its reasons for the action taken.

G. The board's written decision is the official version of the board's action, and the reasons for that action. Other written or oral statements by board members are not recognized as part of the board's official decision or reasons.
[20.11.82.31 NMAC - N, 8/11/08]

20.11.82.32 NOTICE OF BOARD ACTION: The hearing clerk shall provide notice of the board's action to each of the participants and to all other persons who have made a legible written request to the board for notification of the action taken.
[20.11.82.32 NMAC - N, 8/11/08]

20.11.82.33 APPEALS AND STAYS - APPEAL OF REGULATIONS:

A. Appeal of any regulatory change by the board shall be taken in accordance with NMSA 74-2-9.

B. The appellant shall serve a copy of the notice of appeal on the board and on each participant.

C. The appellant shall be responsible for preparation of a sufficient number of copies of the hearing record at the expense of appellant.

D. Unless otherwise provided by NMSA 74-2-9, the filing of an appeal shall not act as a stay of the regulatory change being appealed.
[20.11.82.33 NMAC - N, 8/11/08]

20.11.82.34 STAY OF BOARD REGULATIONS:

A. Any person who is or may be affected by a regulatory change adopted by the board may file a motion with the board seeking a stay of that rule or regulatory change. The motion shall include the reason for, and the legal authority supporting the granting of a stay. The movant shall file the motion at least 15 days before the meeting at which the board will consider the motion. The movant shall serve the motion for a stay as provided by 20.11.82.16 NMAC, and shall also serve all participants in the rulemaking proceeding.

B. Unless otherwise provided by governing law, the board may grant a stay pending appeal of any regulatory change promulgated by the board. The board may only grant a stay if good cause is shown after a motion is filed and a hearing is held.

C. In determining whether good cause exists for granting a stay, the board shall consider:

(1) the likelihood that the movant will prevail on the merits of the appeal;

(2) whether the moving party will suffer irreparable harm if a stay is not granted;

(3) whether substantial harm will result to other interested persons; and

(4) whether harm to the public interest will result.

D. If no action is taken within 60 days after filing of the motion, the board shall be deemed to have denied the motion for stay.
[20.11.82.34 NMAC - N, 8/11/08]

HISTORY OF 20.11.82 NMAC:

NEW MEXICO BOARD OF CHIROPRACTIC EXAMINERS

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 4 CHIROPRACTIC PRACTITIONERS
PART 14 MANAGEMENT OF MEDICAL RECORDS

16.4.14.1 ISSUING AGENCY: New Mexico Board of Chiropractic Examiners, PO Box 25101, Santa Fe, New Mexico 87504.
[16.4.14.1 NMAC - N, 8/9/2008]

16.4.14.2 SCOPE: Chiropractors for licensure who must take a licensing examination for the state of New Mexico.
[16.4.14.2 NMAC - N, 8/9/2008]

16.4.14.3 STATUTORY AUTHORITY: These rules of practice and procedure govern the practice of chiropractic in New Mexico and are promulgated pursuant to and in accordance with the Chiropractic Physician Practice Act, Sections 61-4-3.G and 61-4-4 NMSA 1978.
[16.4.14.3 NMAC - N, 8/9/2008]

16.4.14.4 DURATION: Permanent.
[16.4.14.4 NMAC - N, 8/9/2008]

16.4.14.5 EFFECTIVE DATE: 8/9/2008, unless a later date is cited at the end of a section.
[16.4.14.5 NMAC - N, 8/9/2008]

16.4.14.6 OBJECTIVE: This part establishes requirements and procedures for management of chiropractic records.
[16.4.14.6 NMAC - N, 8/9/2008]

16.4.14.7 DEFINITIONS. "Chiropractic record" means all information maintained by a chiropractic physician relating to the past, present or future physical or mental health of a patient, and for the provision of health care to a patient. This information includes, but is not limited to, the chiropractic physician's notes, reports summaries, and x-rays and laboratory and other diagnostic test results. A patient's complete chiropractic record includes information generated and maintained by the chiropractic physician, as well as information provided to chiropractic physician by the patient, by any other physician who has consulted with or treated the patient, and other information acquired by the chiropractic physician about the patient in connection with the provision of health care to the patient.
[16.4.14.7 NMAC - N, 8/9/2008]

16.4.14.8 RELEASE OF CHIROPRACTIC RECORDS. Chiropractic physicians must provide complete copies of medical records to a patient or to another physician in a timely manner when legally requested to do so by the patient or by a legally designated representative of the patient. This should occur with a minimum of disruption in the continuity and quality of medical care being provided to the patient. If the medical records are the property of a separate and independent organization, the chiropractic physician should act as the patient's advocate and work to facilitate the patient's request for records.

A. Medical records may not be withheld because an account is overdue or a bill for treatment medical records, or other services is owed.

B. A reasonable cost-based charge may be made for the cost of duplicating and mailing chiropractic records. A reasonable charge is not more than $25 and $0.25 per page. Patients may be charged the actual cost of reproduction for electronic records and record formats other than paper, such as x-rays. The board will review the reasonable charge periodically. Chiropractic physicians charging for the cost of reproduction of 16.4.1 NMAC medical records shall give consideration to the ethical and professional duties owed to other physicians and their patients.
[16.4.14.8 NMAC - N, 8/9/2008]

16.4.14.9 CLOSING, SELLING, RELOCATING OR LEAVING A PRACTICE. Due care should be taken when closing or departing from a practice to ensure a smooth transition from the current chiropractic physician to the new treating physician. This should occur with a minimum of disruption in the continuity and quality of medical care being provided to the patient. Whenever possible, notification of patients is the responsibility of the current treating physician.

A. Whenever possible, active patients and patients seen within the previous three years must be notified at least 30 days before closing, selling, relocating or leaving a practice.

B. Whenever possible, patients should be notified within at least 30 days after the death of their chiropractic physician.

C. Notification shall be through a notice in newspaper in the local practice area, and should include responsible entity/agent name of contact to obtain records or request transfer of records, telephone number and mailing address. To reach a maximum number of patients, the notification must run a minimum of two times per month for three months. In addition to a notice in the newspaper, notification may also be through an individual letter to the patient's last known address. Notification shall also be sent to the board.

D. A chiropractic physician or chiropractic physician group should not withhold patient lists or other information from a departing chiropractic physician that is necessary for notification of patients.

E. Patients of a chiropractic physician who leaves a group practice must be notified the chiropractic physician is leaving, notified of the chiropractic physician's new address and offered the opportunity to have their medical records transferred to the departing chiropractic physician at his new practice.

F. When a practice is sold, all active patients must be notified that the chiropractic physician is transferring the practice to another chiropractic physician or entity who will retain custody of their records and that at their written request the records (or copies) will be sent to another physician or entity of their choice.
[16.4.14.9 NMAC - N, 8/9/2008]

16.4.14.10 RETENTION, MAINTENANCE AND DESTRUCTION OF MEDICAL RECORDS.

A. Improper management of medical records, including failure to maintain timely, accurate, legible and complete medical records constitutes a violation of (61-4-10A(16) Chiropractic physicians must post a written copy of their policy or their employer's policy for medical record retention, maintenance and destruction.

B. Written medical record policy shall include:

(1) responsible entity/agent name of contact to obtain records or request transfer of records, telephone number and mailing address;

(2) how the records can be obtained or transferred;

(3) how long the records will be maintained before they are destroyed; and

(4) cost of obtaining copies of records, and of recovering records/transferring records.

C. Chiropractic physicians must retain medical records that they own for at least 2 years beyond what is required by state insurance laws and by medicare and medicaid regulations. Medical records for patients who are minors must be retained for at least 2 years beyond the date that the patient is 18 years old.

D. A log must be kept of all charts destroyed, including the patient's name and date of record destruction.
[16.4.14.10 NMAC - N, 8/9/2008]

HISTORY OF 16.4.14 NMAC:
[RESERVED]

NEW MEXICO BOARD OF CHIROPRACTIC EXAMINERS

This is an amendment to 16.4.3 NMAC, Sections 8 and 9 effective 08/09/08. This also amends the part name.

PART 3 REQUIREMENTS FOR LICENSURE [~~BY EXAMINATION~~]

16.4.3.8 APPLICATION FOR LICENSURE [~~BY EXAMINATION~~]:

A. The board shall recognize successful completion of all parts of the examination conducted by the national board of chiropractic examiners. The board shall examine each applicant in the act of chiropractic adjusting, procedures and methods as shall reveal the applicants qualifications; provided that the board may waive the requirements for the board administered examination upon proof satisfactory completion of the exam conducted by the national board of chiropractic examiners. No application for licensure under the Chiropractic Physician Practice Act, Sections 61-4-1 through 61-4-17 NMSA 1978, shall be deemed complete until the board's administrator certifies that the application contains all of the following:

(1) a completed application form;

(2) a nonrefundable application [~~for license by examination~~] fee as set forth in Subparagraph (a) of Paragraph (1) of Subsection A of 16.4.1.13 NMAC payable by cashier's check or money order;

(3) letter size, notarized copy of original chiropractic diploma;

(4) 2" x 2" photograph attached to the application;

(5) transcript of credits of chiropractic college;

(6) transcripts documenting two years of pre-chiropractic, post-secondary education;

(7) transcript from the national board of chiropractic examiners (parts I, II, III, IV and physiotherapy exam), demonstrating a passing score;

(8) all transcripts must be sent directly from each agency to the New Mexico board;

(9) verification of licensure and good standing in any state where the applicant holds a current or inactive license must be sent directly from the state licensing agency to the New Mexico board;

(10) has had no disciplinary action imposed, nor criminal convictions, [~~enter against any chiropractic license the applicant held or holds;~~] applicant agrees to a national practitioners databank and a federation of chiropractic licensing boards background check;

(11) complete the jurisprudence exam administered by the board with a score of at least 75 percent.

[~~B. Application must be complete and shall be received by the board's administrator no less than 21 days in advance for the practical examination.~~]

[~~C.~~] B. All applications deemed completed by the board's administrator shall be referred to the board for final consideration. [~~The board may deny any applicant the right to take the practical examination in accordance with Sections 61-4-10 NMSA 1978 and the Uniform Licensing Act, Section 6-1-1 through 1-1-~~]

~~31 NMSA 1978.~~]

[~~D.~~] C. No applicant shall be [~~eligible to sit the practical examination~~] reviewed for approval until the application is complete[~~; however, the board may waive the requirement for the board administered examination upon proof of satisfactory completion of the examination conducted by the national board of chiropractic examiners~~].

[~~E.~~] D. If an applicant does not meet the minimal requirements as set forth above, applicant may, at the discretion of the board, be required to take and pass part I, II, III, IV, physiotherapy exam, other NBCE specialty examination or the special purpose examination (SPEC) of the national boards, or any combination thereof.

[~~F.~~] E. The board may designate a professional background information service, which compiles background information regarding an applicant from multiple sources.

[2/27/87, 5/26/89, 9/5/91, 2/12/93, 11/16/97, 10/31/98, 1/29/99; 16.4.3.8 NMAC - Rn & A, 16 NMAC 4.3.8, 1/15/2005; A, 3/15/06; A, 8/30/06; A, 08/9/08]

16.4.3.9 [~~APPLICATION FOR EXAMINATION:~~]

[~~A. No application for examination under the Chiropractic Physician Practice Act, Sections 61-4-1 through 61-4-17 NMSA 1978, shall be deemed complete until the board's administrator certifies that the application contains all of the following:~~

~~(1) a completed application form;~~

~~(2) a nonrefundable application for examination fee as set forth in Subparagraph (c) of Paragraph (1) of Subsection A of 16.4.1.13 NMAC payable by cashier's check or money order;~~

~~(3) written verification sent directly from the college that applicant is in the last trimester, semester, or quarter, is expected to graduate with the next graduating class and the anticipated graduation date;~~

~~(4) 2" x 2" photograph attached to the application;~~

~~(5) transcript of credits of chiropractic college;~~

~~(6) transcripts documenting two years of pre-chiropractic, post-secondary education;~~

~~(7) transcript from the national board of chiropractic examiners (parts I, II, III, IV and physiotherapy exam), demonstrating a passing score;~~

~~(8) all transcripts must be sent directly from each agency to the New Mexico board;~~

~~(9) verification of licensure and good standing in any state where the applicant holds a current or inactive license must be sent directly from the state licensing agency to the New Mexico board;~~

~~(10) completed the jurisprudence exam with a score of at least 75 percent.~~

~~B. All applications deemed completed by the board's administrator shall be referred to the board for final consideration. The board may deny any applicant the right to take the practical examination in accordance with Sections 61-4-10 NMSA 1978 and the Uniform Licensing Act, Section 6-1-1 through 1-1-31 NMSA 1978.~~

~~C. No applicant shall be eligible to sit the practical examination until the application is complete.~~

~~D. If an applicant does not meet the minimal requirements as set forth above, applicant may, at the discretion of the board, be required to take and pass part I, II, III, IV, or the physiotherapy exam or the special purpose examination (SPEC) of the national boards, or any portion of the New Mexico board of chiropractic examiners practical examination, or any combination thereof.~~

~~E. Upon receipt of a letter size, notarized copy of original chiropractic diploma, licensure by examination fee as set forth in Subparagraph (a) of Paragraph (1) of Subsection A of 16.4.1.13 NMAC, update of information submitted on original application and affidavit, a license may be issued at the direction of the chairman.~~

~~F. Upon receipt of a completed application, including all required documentation and fees, the secretary-treasurer or the delegate of the board will review and may approve the application. The results of the background check must either indicate no negative findings, or if there are negative findings, those findings will be considered by the board. The board shall formally accept the approval of the application at the next scheduled meeting.~~] [RESERVED]

[1/29/99; 16.4.3.9 NMAC - Rn & A, 16 NMAC 4.3.9, 1/15/2005; A, 3/15/06; Repealed, 08/9/08]

NEW MEXICO BOARD OF CHIROPRACTIC EXAMINERS

This is an amendment to 16.4.4 NMAC Section 8, effective 8/9/08.

16.4.4.8 LICENSURE [~~WITHOUT EXAMINATION~~]:

A. In accordance with Section 61-4-8 NMSA 1978, of the New Mexico Chiropractic Physician Practice Act, the board may, at its discretion, issue licenses to practice chiropractic in New Mexico to doctors who provide evidence of meeting the following minimal requirements:

(1) is of good moral character and has maintained an active practice for at least seven of the last ten years prior to the filing of the application as a doctor of chiropractic in another state, territory, country or foreign jurisdiction whose licensure requirements are equal to or exceed those of New Mexico; and

(a) is a doctor of chiropractic diploma from a council on chiropractic education accredited or board accepted equivalent chiropractic college and has served in the military services of the United States for two years or more within one year prior to application; and

(b) is an applicant showing evidence of having passed all examinations conducted by the "NBCE".

(2) has had no disciplinary action imposed, nor criminal convictions entered against any chiropractic license the applicant held or holds; applicant agrees to a national practitioners databank and a federation of chiropractic licensing boards background check;

(3) has never been found guilty of any action which, had it been committed in New Mexico, would be grounds for disciplinary action against the license;

(4) provides national board transcripts;

(5) provides pre-chiropractic college transcripts.

B. Applicant must complete application for licensure without examination, pay nonrefundable application fee, and should meet all other applicable requirements of New Mexico statutes pertaining to the practice of chiropractic and all other applicable provisions of the board's rules. The applicant will be required to completed the jurisprudence exam with a score of at least 75 percent.

C. If an applicant does not meet the minimal requirements of 61-4-8.B NMSA 1978, applicant may at the discretion of the board, be required to take and pass part I, II, III or IV, and phsyiotherapy or the special purpose examination (SPEC) of the national boards [~~or any portion of the New Mexico board of chiropractic examiners practical examination or any combination thereof~~].

D. Upon receipt of a completed application, including all required documentation and fees, the secretary-treasurer or the delegate of the board will review and may approve the application. The results of the background check must either indicate no negative findings, or if there are negative findings, those findings will be considered by the board. The board shall formally accept the approval of the application at the next scheduled meeting.

E. The board may designate a professional background information

service, which compiles background information regarding an applicant from multiple sources.
[3/22/95, 11/16/97; 10/31/98; 16.4.4.8 NMAC - Rn & A, 16 NMAC 4.4.8, 1/15/2005; A, 3/15/06; A, 8/30/06; A, 8/9/08]

NEW MEXICO BOARD OF CHIROPRACTIC EXAMINERS

This is an amendment to 16.4.13 NMAC section 8, effective 8/9/08.

16.4.13.8 REINSTATEMENT OF CHIROPRACTIC LICENSURE:

A. Any person whose license has been suspended, revoked or which has lapsed may apply to the board for reinstatement of the license at any time within two (2) years of the suspension, revocation or lapse. [~~Any person whose license has been in inactive status may apply for reinstatement after one (1) year.~~]

(1) In making application for reinstatement, the applicant should state why the license should be reinstated and should specifically set forth any changed circumstances which would justify reinstatement.

(2) Applicant must include in the application, evidence that applicant meets the current requirements for licensure.

(3) Any licensed chiropractor applying for reinstatement of a license must pay all back renewal and penalty fees for each year of suspension, revocation or lapse, an application fee as set forth in Subparagraph (d) of Paragraph (1) of Subsection A of 16.4.1.13 NMAC and provide proof of attendance of continuing education hours as set forth in Subsection A of 16.4.10.8 NMAC for each year of suspension, revocation or lapse to a maximum of two years.

[~~(4) Any licensed chiropractor applying for reinstatement of a license from inactive status must have fulfillment of the continuing education requirements for the year in which the applicant petitions for a change in status and payment of reinstatement of license fees, active renewal fees, impairment fees, and late fees required by the board. Applicant must include in the application, evidence that the applicant meets the current requirements for licensure.~~]

B. The board may require an applicant to complete certain education or training requirements, in addition to any continuing education requirements; to be completed prior to or after reinstatement to ensure that the applicant is competent to practice chiropractic. The board may, in its discretion, require that an applicant for reinstatement take and pass a written [~~and/or oral~~] examination as prescribed by the board.

C. Upon receipt of an application for reinstatement, the board shall grant the applicant a hearing, at which time the applicant may appeal to the board to reinstate the license.

D. After two years, the applicant must apply for licensure without examination.

E. [~~Has no disciplinary action imposed or criminal convictions entered against any chiropractic license the applicant held or holds;~~] Applicant agrees to a national practitioners databank and a federation of chiropractic licensing boards background check.
[10/30/69, 2/27/87, 2/12/93, 11/16/97; 16.4.13.8 NMAC - Rn & A, 16 NMAC 4.13.8, 3/15/06; A, 8/9/08]

NEW MEXICO HIGHER EDUCATION DEPARTMENT

5.55.4 NMAC, Dual Credit, filed 12-17-2007 is repealed and replaced by 5.55.4 NMAC, Dual Credit, effective 7-31-2008.

NEW MEXICO HIGHER EDUCATION DEPARTMENT

TITLE 5 POST-SECONDARY EDUCATION
CHAPTER 55 PUBLIC POST-SECONDARY EDUCATION GENERAL PROVISIONS
PART 4 DUAL CREDIT

5.55.4.1 ISSUING AGENCY: New Mexico Higher Education Department (NMHED)
[5.55.4.1 NMAC - Rp, 5.55.4.1 NMAC, 07/31/08]

5.55.4.2 SCOPE: This rule applies to public school districts (high schools, charter schools and state-supported schools), high school students who attend secondary schools, and public postsecondary institutions in New Mexico. Districts and public postsecondary institutions are required to implement rules no later than the beginning of the 2008-2009 school year.
[5.55.4.2 NMAC - Rp, 5.55.4.2 NMAC, 07/31/08]

5.55.4.3 STATUTORY AUTHORITY: Section 22-2-1, 22-2-2, 9-25-8, 21-1-1.2 NMSA 1978.
[5.55.4.3 NMAC - Rp, 5.55.4.3 NMAC, 07/31/08]

5.55.4.4 DURATION: Permanent
[5.55.4.4 NMAC - Rp, 5.55.4.4 NMAC, 07/31/08]

5.55.4.5 EFFECTIVE DATE: July 31, 2008, unless a later date is cited at the end of a section.
[5.55.4.5 NMAC - Rp, 5.55.4.5 NMAC, 07/31/08]

5.55.4.6 OBJECTIVE: The purposes of dual credit are:

A. to increase educational opportunities for high school students, and

B. to increase the overall quality of instruction and learning available through secondary schools.
[5.55.4.6 NMAC - Rp, 5.55.4.6 NMAC, 07/31/08]

5.55.4.7 DEFINITIONS:

A. "ACT" is the academic competency test.

B. "Agreement" is the dual credit master agreement.

C. "Classification of instructional program" or "CIP" is a taxonomic coding scheme that contains titles and descriptions of instructional programs, primarily at the postsecondary level. The CIP was originally developed to facilitate the United States department of education national center for education statistics' collection and reporting of postsecondary degree completions, by major field of study, using standard classifications that capture the majority of program activity.

D. "Common core" refers to the thirty-five (35) semester-hour common core of general education lower-division courses eligible for transfer to other New Mexico postsecondary institutions as per 5.55.3.9 NMAC.

E. "Concurrent enrollment" refers to enrollment of high school students in courses at the postsecondary level that are not designated as dual credit. This includes courses not listed within the dual credit master agreement between the eligible district and postsecondary institution. Students who are concurrently enrolled may also be enrolled in the dual credit program if they meet eligibility requirements as specified in 5.55.4 NMAC and 6.30.7 NMAC.

F. "Core course" means courses required for high school graduation as defined in 22-13-1.1 NMSA, 1978, excluding electives.

G. "Developmental course" refers to courses with CIP codes of 32.0101, 32.0107 or 32.0199 that fall within the basic skills or career exploration/awareness skills categories.

H. "District" as defined in 6.30.2.9 NMAC means a public school district, including a charter school or charter school district, a state supported educational institution and a state-chartered school.

I. "Dual credit council" is an advisory group consisting of staff of the public education department and higher education department that issues recommendations to the secretaries of the public education and higher education departments regarding dual credit issues outside of the scope of the agreement.

J. "Dual credit program" means a program that allows high school students to enroll in college-level courses offered by a postsecondary institution that may be academic or career technical but not remedial or developmental, and simultaneously to earn credit toward high school graduation and a postsecondary degree or certificate.

K. "Elective course" means courses defined and approved as such by local school boards.

L. "FERPA" is the Family Educational Rights and Privacy Act [20 U.S. Code 1232g].

M. "Form" is the dual credit request form.

N. "General fees" as defined in 5.7.18 NMAC and Subsection B of Section 21-1-4-NMSA 1978 means a fixed sum charged to students for items not covered by tuition and required of such a proportion of all students that the student who does not pay the charge is an exception. General fees include fees for matriculation, library services, student activities, student union services, student health services, debt service and athletics. An institution may charge fees in addition to general fees that are course-specific or that pertain to a smaller proportion of students.

O. "Individualized education program" or "IEP" means a written statement for a child with a disability that is developed, reviewed, and revised in accordance with 34 CFR Secs. 300.320 through 300.324.

P. "Postsecondary institution" refers to a public postsecondary educational institution operating in the state, including a community college, branch community college, and four-year educational institution.

Q. "Remedial course" refers to courses with CIP codes of 32.0104 or 32.0108 that fall within the numeracy and computational skills, precollegiate mathematics skills, precollegiate reading skills, precollegiate writing skills, or communications skills categories.

[5.55.4.7 NMAC - Rp, 5.55.4.7 NMAC, 07/31/08]

5.55.4.8 UNIFORM MASTER AGREEMENT.

A. The agreement specifies the means by which the state will provide equal opportunities to all public high school students who wish to participate in the dual credit program.

B. Districts and postsecondary institutions providing dual credit programs shall complete the agreement and the district shall submit the completed agreement to the public education department.

C. A completed agreement shall contain signatures from all parties and includes an appendix developed collaboratively by the district and postsecondary institution that specifies eligible dual credit courses.

D. Districts may complete agreements with multiple postsecondary institutions.

E. A fully executed copy of each agreement shall be submitted by the district to the public education department within 10 days of approval.

F. The agreement:

(1) specifies eligible courses, academic quality of dual credit courses, student eligibility, course approval, course requirements, required content of the form, state reporting, liabilities of parties, and student appeals; and

(2) states the roles, responsibilities, and liabilities of the district, the postsecondary institution, student, and the student's family.

G. Duties and responsibilities of the postsecondary institution. The postsecondary institution shall:

(1) designate a representative to review and sign the completed form with the understanding that only forms endorsed by all parties shall constitute a dual credit approval request;

(2) determine, in collaboration with the district, the required academic standing of each student eligible to participate in the dual credit program;

(3) collaborate with the district to reach agreement on admission and registration of eligible dual credit students for the stated semester;

(4) employ a method of qualifying the student for dual credit that demonstrates that the student has the appropriate skills and maturity to benefit from the instruction requested;

(5) provide advisement to review the appropriateness of each student's enrollment in a course prior to registration in terms of academic readiness, age requirements, and programmatic issues;

(6) provide the form to eligible students and appropriate district staff online and in hard copy;

(7) approve the form for each student on a course-by-course basis each semester based on each student's prior coursework, career pathway, or academic readiness;

(8) provide a copy of each approved form to the appropriate district representative;

(9) provide course placement evaluation and consider a high school college readiness assessment to verify a student's academic skill level and to ensure compliance with course prerequisites;

(10) provide information and orientation, in collaboration with the district, to the student and parent or guardian regarding the responsibilities of dual credit enrollment including academic rigor, time commitments, and behavioral expectations associated with taking college courses and the importance of satisfactorily completing the postsecondary institution credits attempted in order for dual credit to be awarded;

(11) inform students of course requirement information which includes course content, grading policy, attendance requirements, course completion requirements, performance standards, and other related course information;

(12) advise the parent or guardian of FERPA rules;

(13) waive all general fees for dual credit courses;

(14) waive tuition for high school students taking dual credit courses;

(15) make every effort to adopt textbooks for at least three years;

(16) provide the district, within the first thirty days of the academic term, access to each student's official schedule of classes as verification of registration; the district shall notify the postsecondary institution if the report is in conflict with the school endorsed registration;

(17) track progress of dual credit enrolled students on the issue of academic performance and provide reports, as needed, to the district;

(18) retain the official transcript or grade report of the dual credit student that records the term of enrollment, courses/credits attempted, courses/credits completed, grades and grade point average earned;

(19) release, at the request of the student, official postsecondary institution transcripts in accordance with the postsecondary institution's transcript request practices;

(20) provide final grades to the district for each dual credit student;

(21) deliver final grades for all dual credit students to the district with sufficient time to be included with final grades; this schedule shall be defined by the parties in the agreement and shall address the time frame appropriate for determining student graduation from high school;

(22) comply with data collection

and reporting provisions in 5.55.4.12 NMAC;

(23) approve faculty for all dual credit courses;

(24) retain educational records in accordance with New Mexico statutes and record retention regulations as per 1.20.3 NMAC;

(25) have a student appeals process pertaining to student enrollment in dual credit programs (postsecondary institution decisions are final); and

(26) have the right to appeal to the dual credit council on issues related to implementing the dual credit program, agreement, and rules.

H. Duties and responsibilities of the district. The district shall:

(1) designate a representative to collaborate with the postsecondary institution to reach agreement on admission and registration of eligible dual credit students for the stated semester;

(2) determine, in collaboration with the postsecondary institution, the required academic standing of each student eligible to participate in the dual credit program;

(3) collaborate with the postsecondary institution to reach agreement on admission and registration of eligible dual credit students for the stated semester;

(4) employ a method of qualifying the student for dual credit based on factors which may include academic performance review, use of next step plan, assessments, advisement and career guidance, and therefore recommend enrollment at the postsecondary institution with evidence that the student has the appropriate skills and maturity to benefit from the instruction requested;

(5) provide information and orientation to students about opportunities to participate in dual credit programs during student advisement, academic support, and formulation of annual next step plans;

(6) provide the form to eligible students and appropriate district staff online and in hard copy;

(7) approve the form for each student on a course-by-course basis each semester based on each student's prior coursework, career pathway, or academic readiness;

(8) provide information and orientation, in collaboration with the postsecondary institution, to the student and student's family regarding the responsibilities of dual credit enrollment including academic rigor, time commitments, and behavioral expectations associated with taking college courses and the importance of satisfactorily completing the college credits attempted in order for dual credit to be awarded;

(9) inform students of course requirement information which includes course content, grading policy, attendance requirements, course completion requirements, performance standards, and other related course information;

(10) notify the postsecondary institution if the student's official schedule of classes is in conflict with the school endorsed registration;

(11) provide appropriate accommodations and services for special education students while the students are enrolled in dual credit classes, including academic adjustments and auxiliary aids and services for eligible students across educational activities and settings (e.g. equipping school computers with screen-reading, voice recognition or other adaptive hardware or software and providing note-takers, recording devices, or sign language interpreters, or other adaptation as required by law);

(12) inform students in need of accommodations or other arrangements of the need to speak directly with the disabilities coordinator at the postsecondary institution;

(13) work collaboratively with the postsecondary institution to submit a student's request for change in registration according to postsecondary institution policies and within officially published deadlines;

(14) make it clear to students that if they fail or withdraw from dual credit classes that they were intending to use to substitute for a high school requirement that they will have to make up those credits in order to graduate; the dual credit course grade will appear on the student high school transcript;

(15) pay the cost of the required textbooks and other course supplies for the postsecondary course the dual credit student is enrolled in through purchase arrangements with the bookstore at the postsecondary institution or other cost-efficient methods;

(16) collaborate with the postsecondary institution to offer dual credit courses at the high school site according to district site time blocks;

(17) furnish an official high school transcript to the postsecondary institution if required by the postsecondary institution;

(18) record, unchanged, the grade given to the dual credit student by the postsecondary institution on each student high school transcript;

(19) retain educational records in accordance with New Mexico statutes and record retention regulations as per 1.20.2 NMAC;

(20) comply with data collection and reporting provisions in 5.55.4.12 NMAC;

(21) have a student appeals process pertaining to student enrollment in dual credit programs (district decisions are final); and

(22) have the right to appeal to the dual credit council on issues related to implementing the dual credit program, agreement, and rules.

I. Duties and responsibilities of the student. The student shall:

(1) qualify for dual credit courses offered in the fall, winter and summer by:

(a) being enrolled during the fall and winter in a district in one-half or more of the minimum course requirements approved by the New Mexico public education department for public school students;

(b) obtaining permission from the district representative (in consultation with the student's individualized education program team, as needed), the student's parent or guardian, and postsecondary institution representative through a fully executed form prior to enrolling in a dual credit course; and

(c) meeting postsecondary institution requirements to enroll as a dual credit student;

(2) discuss potential dual credit courses with the appropriate district and postsecondary institution staff, including postsecondary institution admission and registration requirements, course requirements, credits to be attempted, credits to be awarded, scheduling under dual credit, and implications for failure to successfully complete the course;

(3) obtain course requirements for each course, including course prerequisites, course content, grading policy, attendance requirements, course completion requirements, performance standards, and other related course information;

(4) meet the prerequisites and requirements of the course(s) to be taken;

(5) complete the form available online or in hard copy from the district or postsecondary institution;

(6) obtain approval for enrolling in the dual credit program each semester by acquiring all necessary signatures on the form;

(7) register for courses during the postsecondary institution's standard registration periods (note: enrollments shall not be permitted after the close of posted late registration);

(8) discuss any request for a change in registration (add, drop, withdrawal) and complete all necessary forms and procedures with appropriate district and postsecondary institution staff;

(9) comply with the district and postsecondary institution student code of conduct and other institutional policies;

(10) have rights and privileges that include:

(a) the rights and privileges equal to those extended to district and postsecondary institution students, unless otherwise excluded by any section of this agreement;

(b) use of the postsecondary institution library, course-related labs and other instructional facilities, use of the postsecondary institution programs and services such as counseling, tutoring, advising, and special services for the students with disabilities, and access to postsecondary institution personnel and resources as required; and

(c) the right to appeal, in writing to the district or postsecondary institution, as applicable, any decision pertaining to enrollment in the dual credit program;

(11) return the textbooks and unused course supplies to the district when the student completes the course or withdraws from the course (subject to provisions in Subsection B of Section 22-15-10 NMSA 1978 regarding lost or damaged instructional material);

(12) arrange transportation to the site of the dual credit course; depending upon the time and course location, the student may have access to transportation through the district if the dual credit course is offered during the school day;

(13) be responsible for course-specific (e.g. lab, computer) fees;

(14) allow educational records to be retained and disseminated in accordance with the requirements of the FERPA;

(15) sign the FERPA release form, along with student parent or guardian, if applicable, in order to participate in dual credit courses; and

(16) abide by regular operating calendars, schedules and associated requirements of both the district and postsecondary institution; in instances in which the calendars are incongruent, the student is required to independently satisfy both calendar requirements and may consult with district counselors for assistance.

[5.55.4.8 NMAC - Rp, 5.55.4.8 NMAC, 07/31/08]

5.55.4.9 LIMITATIONS OF THE AGREEMENT.

A. With the exception of the appendix, the agreement may not be altered or modified by either party.

B. The agreement shall automatically renew for additional fiscal years unless either party notifies the other party of their intent not to renew 60 days before the end of the fiscal year.

C. Districts, in collaboration with postsecondary institutions, may modify the list of dual credit courses in the appendix of the agreement. Modifications shall be submitted to the higher education department and the public education department by the end of each semester.

[5.55.4.9 NMAC - Rp, 5.55.4.9 NMAC, 07/31/08]

5.55.4.10 LIABILITIES OF PARTIES.

A. Dual credit status shall neither enhance nor diminish on-campus liabilities for the district or the postsecondary institution.

B. Management of risk and liabilities shall be in accordance with district and postsecondary institution policies and codes of conduct.

C. Personal liabilities for the student shall be equal to those of regular postsecondary institution students.

[5.55.4.10 NMAC - Rp, 5.55.4.10 NMAC, 07/31/08]

5.55.4.11 ELIGIBLE COURSES.

A. Types of courses.

(1) College courses that are academic or career technical (but not remedial or developmental) and that simultaneously earn credit toward high school graduation and a postsecondary degree or certificate shall be eligible for dual credit.

(2) Dual credit courses may be taken as elective high school credits.

(3) Dual credit courses may satisfy the requirements of high school core courses when the department standards and benchmarks are met and curriculum is aligned to meet postsecondary requirements.

(4) Dual credit courses may substitute for high school core courses when the dual credit council determines there are exigent circumstances. For example, there is limited high school capacity, staff, space or scheduling and the cabinet secretaries approve the dual credit council recommendation.

(5) College courses eligible for dual credit shall meet the rigor for postsecondary institution credit and be congruent with the postsecondary institution's academic standards.

(6) Dual credit courses offered in high school settings shall conform to college academic standards.

(7) Course requirements for high school students enrolled in dual credit courses shall be equal to those of regular college students.

B. Identifying courses.

(1) The district in collaboration with the postsecondary institution shall determine a list of academic and career technical courses eligible for dual credit for inclusion into the appendix.

(2) The appendix shall indicate whether the course is a core or elective high school course, the higher education common course number, if applicable, course subject and number, course title, location of course delivery and semesters offered.

(3) The district shall annually submit the appendix to the higher education department and the public education department; Subsection C of 5.55.4.9 NMAC still applies.

(4) The higher education department and the public education department shall post the appendix on their respective websites and update the appendix as needed.

C. Course delivery.

(1) Dual credit courses may be offered at districts, postsecondary institutions, and off-campus centers as determined by the district in collaboration with the postsecondary institution offering the courses.

(2) Dual credit courses may be delivered during or outside of regular district hours.

(3) Postsecondary institutions may offer dual credit courses via distance learning (ITV, online, hybrid, correspondence) in accordance with 6.30.7 NMAC and 5.55.4 NMAC as this option becomes available and cost-effective. All dual credit course rules apply.

(4) Districts and postsecondary institutions participating in the cyber academy shall be subject to applicable rules pertaining to it.

D. Semesters dual credit may be taken; caps for dual credit; nature of high school credit earned.

(1) Eligible students may enroll in dual credit courses year-round.

(2) There is no state limit to the number of credits a student may earn through dual credit in an academic term; however, the student must meet eligibility requirements.

(3) Unless otherwise approved by the secretaries of the higher education and public education departments, one secondary school credit shall be awarded for the successful completion of three credit hours of postsecondary institution instruction for elective courses not comparable to existing district elective courses. If the district and postsecondary institution determine that a different ratio is warranted for a particular dual credit course comparable to district core courses in order to meet public education department standards and benchmarks, they may appeal to the council, which may recommend a different ratio to the secretaries of the public education and higher education departments. The joint decision of the public education and higher education department cabinet secretaries shall be final.

E. Dual credit council.

(1) The secretaries of the higher education department and public education

department shall appoint individuals to a dual credit council consisting of six members.

(2) Council composition. The council shall consist of an equal number of higher education department and public education department staff. The higher education and public education department staff serve as council chairs in alternating years.

(3) The council shall administer an appeals process for district and postsecondary institution representatives to address issues outside the scope of the agreement, including the determination of alignment of course content to determine the appropriate credit ratio.

(4) The council shall issue recommendations to the department secretaries on issues not addressed in the agreement.

(5) Districts and postsecondary institutions shall be allowed to continue current practices regarding core courses offered for dual credit until the council issues its recommendations or no later than the beginning of the 2009-2010 school year, the time that dual credit courses become a high school graduation requirement.

(6) The higher education department and public education department secretaries shall act jointly upon dual credit council recommendations.

[5.55.4.11 NMAC - Rp, 5.55.4.11 NMAC, 07/31/08]

5.55.4.12 DATA COLLECTION AND REPORTING.

A. Data collection.

(1) Each semester, the form shall be used to document each student request for enrollment in dual credit courses and the review and approval process within the district and postsecondary institution. The postsecondary institution may require additional forms and information from the student.

(2) A completed form shall contain the high school student first name, middle initial, and last name, student identification number, student grade level, student address (street address, city, state, and zip code), student telephone number, ACT high school code, secondary school name, postsecondary institution name, postsecondary institution course information (schedule number, course number, course section, course title, day, time, location, higher education credits, high school credits semester, year), a signed FERPA release form, required signatures, check boxes that indicate: whether form was completed and signed by all parties, whether student meets course prerequisites, and, if applicable, whether student high school record was received; applicable placement exam scores, high school grade point average, expected graduation date, and, if applicable, date of birth.

(3) In the event of scheduling changes, the postsecondary institution may change course information.

(4) Each district and postsecondary institution shall use the completed form to capture dual credit student data.

(5) Each district and postsecondary institution shall devise procedures for capturing dual credit data from the form.

(6) If applicable, each postsecondary institution shall bear responsibility for obtaining each dual credit student's social security number to meet data reporting requirements.

(7) Each postsecondary institution shall capture the public school student identification number retrieved from the completed form for each dual credit high school student.

(8) The public education department shall modify student transcripts to include the student identification number.

(9) The public education department shall capture the postsecondary institution course subject and number and course title from the appendix of each completed agreement.

B. Data reporting.

(1) For each completed form received, each district shall indicate which courses a dual credit student takes within the public education department data system.

(2) Each postsecondary institution shall report dual credit student data to the higher education department.

(3) Each district shall submit the dual credit report during the appropriate reporting period to the public education department that contains:

(a) the number of dual credit students enrolled in college courses; and

(b) the courses taken and grades earned of each dual credit student.

(4) Each postsecondary institution shall submit the dual credit report during the appropriate reporting period to the higher education department that contains:

(a) the number of dual credit students enrolled in college courses; and

(b) the courses taken and grades earned of each dual credit student.

(5) The higher education department and the public education department shall verify and reconcile the respective dual credit reports at the end of each academic year.

(6) The public education department shall report to the legislature the high school graduation rates for participating districts for dual credit students once the students graduate from high school.

(7) The higher education department shall report to the legislature on the New Mexico postsecondary institutions dual credit students ultimately attend.

(8) The higher education department and the public education department shall annually report to the legislature the estimated cost of providing the statewide dual credit program, including tuition, fees, textbooks, and course supplies.

[5.55.4.12 NMAC - Rp, 5.55.4.12 NMAC, 07/31/08]

5.55.4.13 NON PUBLIC SCHOOL STUDENTS.

A. A home school, private school, or tribal school student who meets the eligibility criteria may receive both high school and college credit, provided that the student pays the full cost of the college courses.

B. Non public school students taking college courses for both high school and college credit shall be considered as being concurrently enrolled by the postsecondary institution for the purposes of data reporting.

[5.55.4.13 NMAC - Rp, 5.55.4.13 NMAC, 07/31/08]

HISTORY OF 5.55.4 NMAC:

History of Repealed Material:

5.55.4 NMAC, Dual Credit, filed 08/30/2006 - Repealed effective 01/01/08.

5.55.4 NMAC, Dual Credit, filed 12/17/2007 - Repealed effective 07/31/2008.

NEW MEXICO HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

8.100.130 NMAC, General Operating Policies - Eligibility and Verification Standards, filed March 26, 2001, is repealed and replaced by the 8.100.130 NMAC, General Operating Policies - Eligibility and Verification Standards, effective August 1, 2008.

NEW MEXICO HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 100 GENERAL PROVISIONS FOR PUBLIC ASSISTANCE PROGRAMS
PART 130 GENERAL OPERATING POLICIES - ELIGIBILITY AND VERIFICATION STANDARDS

8.100.130.1 ISSUING AGENCY: New Mexico Human Services Department.

[8.100.130.1 NMAC - Rp, 8.100.130.1 NMAC, 08/01/2008]

8.100.130.2 SCOPE: The rule

applies to the general public.
[8.100.130.2 NMAC - Rp, 8.100.130.2 NMAC, 08/01/2008]

8.100.130.3 STATUTORY AUTHORITY:

A. Section 27 NMSA 1978 (1992 Repl.) provides for the department to "...adopt, amend and repeal bylaws, rules and regulations..." It also provides for administration of public assistance programs.

B. The income support division (ISD) of the human services department (HSD) was created by the HSD Secretary under authority granted by Section 9-8-6-B-(3) NMSA 1978.
[8.100.130.3 NMAC - Rp, 8.100.130.3 NMAC, 08/01/2008]

8.100.130.4 DURATION: Permanent.
[8.100.130.4 NMAC - Rp, 8.100.130.4 NMAC, 08/01/2008]

8.100.130.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.100.130.5 NMAC - Rp, 8.100.130.5 NMAC, 08/01/2008]

8.100.130.6 OBJECTIVE: The objective of these regulations is to provide general policy and procedures for income support division (ISD) administered programs.
[8.100.130.6 NMAC - Rp, 8.100.130.6 NMAC, 08/01/2008]

8.100.130.7 DEFINITIONS: [Reserved]
[8.100.130.7 NMAC - Rp, 8.100.130.7 NMAC, 08/01/2008]

8.100.130.8 PRINCIPLES OF ELIGIBILITY: The income support division (ISD) is responsible for administering food, cash, energy, and medical assistance programs. These programs are funded through federal or state sources and provide assistance to individuals who meet certain eligibility factors. State and federal regulations determine eligibility factors for each program. ISD determines if an individual qualifies for a program, and ensures that eligible individuals receive the assistance as quickly as possible and, in any event, within the application time frames for the applicable program.

A. Proof of eligibility: Determining eligibility for assistance requires that certain verification regarding an applicant/recipient's circumstances be made available to ISD. This verification is retained in the case record or noted in the case narrative.

(1) Applicant/recipient responsibility: The applicant/recipient is responsible to provide and obtain the verification necessary to determine eligibility.

(2) ISD responsibility: ISD is responsible for the following:

(a) to explain program participation requirements and the program specific eligibility factors to applicants/recipients;

(b) to explain the information and documents that must be provided to establish eligibility under each eligibility factor for a specific program;

(c) to offer and provide assistance in obtaining verification of an eligibility factor when the applicant/recipient indicates that verification may be difficult or costly to obtain; difficulty in obtaining verification may arise as a result of such circumstances as an applicant/recipient's limited ability to read, speak or understand the English language, mental impairments, physical illness, disability, lack of funds, lack of transportation or lack of knowledge about how to obtain the information; assistance by the caseworker includes explaining written information orally in the applicant/recipient's language, providing an interpreter, providing an address or telephone number of a person or agency, making telephone or written inquiries, allowing an applicant/recipient to use the telephone, locating a document, instructing an applicant in obtaining a document, requesting a document on behalf of an applicant/recipient or contacting a collateral contact; the assistance offered and provided is based on the particular needs of the applicant and the caseworker's ability to address those needs;

(d) applicants/recipients shall be informed in writing of their responsibility to provide necessary verification.

(3) Incomplete information: When available information is inconclusive, incomplete or indefinite, HSD shall be responsible for explaining, in writing, what questions remain and how they can be resolved. The explanation must make it clear that eligibility cannot be established without the information or documents and that failure to provide them shall result in denial, reduction or termination of assistance.

(a) The applicant/recipient shall also be informed they may reapply at any time but that the information, documentation or actions may affect the reapplication. If the applicant/recipient does not provide all of the verification needed, a decision shall be made to the extent possible, based on the existing verified information.

(b) When assistance is denied, reduced, delayed or terminated due to failure to provide information or documents as requested, the case record must contain the explanation that such failure is the basis for the action. The client shall be informed in writing of the action.

B. Failure to provide verification: An applicant/recipient cannot be considered eligible for assistance until necessary verification is obtained. To the extent possible, the caseworker shall make eligibility determinations based on verified eligibility issues rather than failure to provide information.

C. Applicants/recipients may submit documentary evidence in person, by mail, facsimile, or other electronic device or through an authorized representative.
[8.100.130.8 NMAC - Rp, 8.100.130.8 NMAC, 08/01/2008]

8.100.130.9 METHODS OF VERIFICATION:

A. Verification to determine eligibility and benefit level is obtained through six methods. Not all methods will necessarily be used in each case. The six methods are outlined in subsections B - G of this section as well as the circumstance in which they may be used.

B. Prior case data not subject to change: Verification of an eligibility factor not subject to change which previously has been verified is accepted. At the application interview, the caseworker shall advise the applicant/recipient of any eligibility factors which have previously been established through documents in HSD's possession and that are not subject to change. The caseworker shall not require further verification of any eligibility factors already established. Such factors include, U.S. citizenship, permanent residency, birth date, relationship, social security enumeration and deprivation due to the death of a parent.

C. Government data: Every applicant/recipient shall be informed that the information provided is subject to verification through government data systems. The caseworker shall review with the applicant/recipient information received from government data systems. The caseworker shall not require further verification of such information unless it is disputed by the applicant or the information is otherwise questionable as defined in 8.100.130.12 NMAC. Government data checks are automatically made and are not considered to be collateral contacts. The government data checked includes, but are not limited to:

(1) SSA and SSI information through the beneficiary data exchange (BENDEX) and the state data exchange (SDX) systems:

(a) the household shall be given an opportunity to verify the information from another source if the SDX or BENDEX information is contrary to the information provided by the household or is unavailable;

(b) eligibility and benefit level

determination shall not be delayed past the application processing standards of 8.100.130.11 NMAC of this part if SDX or BENDEX data is unavailable;

(2) wage data and unemployment compensation benefits (UCB) through the interface with the New Mexico department of workforce solutions (NMDWS) - unemployment insurance database;

(3) interest, dividends, unearned income and self employment wages through interfaces with the BENDEX wage data and internal revenue service (IRS) available through income and eligibility verification systems (IEVS):

(a) if the IEVS-obtained information is questionable, this information shall be considered unverified upon receipt and the caseworker shall take action to request verification of the information;

(b) except as noted in this paragraph, prior to taking action to terminate, deny or reduce benefits based on IEVS-obtained information, the caseworker shall request verification of the information;

(4) vehicle registration and driver's license information available from the New Mexico motor vehicle division; and

(5) child support payment information and absent parent information available from the child support enforcement division.

(6) Restrictions: Information on earnings, benefits, resources and absent parents disclosed through government data systems shall be used only for the purpose of:

(a) verifying an applicant/recipient's eligibility;

(b) verifying the proper amount of benefits;

(c) investigating to determine whether recipients received benefits to which they were not entitled; and

(d) substantiating information which will be used in conducting criminal or civil prosecution based on receipt of benefits to which recipients were not entitled.

D. Documentary evidence is the primary source of verification for information not established in prior case information or government data. Obtaining necessary verification through documentary evidence readily available to the applicant/recipient shall always be explored before collateral contacts, home visits, or sworn statements are used. Documentary evidence consists of a written confirmation of a household's circumstances. Acceptable verification is not limited to any single type of document. The types of documents which may be accepted as verification are specified under the sections pertaining to non-financial, financial and allowances/deductions verification standards later in this chapter. The enumeration of certain types of documents is not meant to exclude other sources of information that the client might be able to provide. The caseworker shall provide applicants/recipients with receipts for verification documents provided subsequent to the interview.

E. Collateral contacts: A collateral contact is an oral or written confirmation of a household's circumstances by a person outside the household. The caseworker shall document the reason for utilizing a collateral contact in the case file.

(1) A collateral contact can be used only when the applicant/recipient selects a collateral contact as the source of verification and:

(a) the applicant/recipient indicates difficulty in obtaining acceptable documentary evidence; or

(b) the documentary evidence provided by the applicant/recipient is inadequate or questionable.

(2) Selection of a collateral contact: The applicant/recipient and the caseworker shall select a mutually agreed upon collateral contact. A collateral contact must have knowledge of the applicant/recipient's circumstances and must be able to give accurate third party information.

(a) The caseworker may select a collateral contact only if the household fails to designate one or designates one who lacks knowledge of the applicant/ recipient's circumstances or cannot give accurate information. If the applicant/recipient does not agree to the collateral contact and does not designate an acceptable collateral contact, the application may, in appropriate circumstances, be denied for failure to verify.

(b) A collateral contact shall not be rejected solely based on the following criteria:

(i) they are related to the applicant/recipient;

(ii) they are a recipient of public assistance; or

(iii) because they do not have a telephone.

(3) Failure on the part of a collateral contact: The caseworker shall not deny or delay an eligibility decision solely because of failure of a collateral contact to provide information. The caseworker shall decide the applicant/recipient's eligibility and benefit amounts based on all readily available information.

F. Home visits: Home visits may be used as verification only when documentary evidence is insufficient to make a firm determination of eligibility or benefit level, or cannot be obtained. Home visits shall be selected as a method of verification with the applicant/recipient's consent. The caseworker shall schedule the home visit with the applicant/recipient in advance during normal business hours. The caseworker shall document the reason for the home visit in the case record.

G. Sworn statements:

(1) If the applicant/recipient has an immediate need for assistance, the caseworker shall accept and, if necessary, assist the applicant/recipient to identify necessary factors to be included in the statement, an applicant/recipient's sworn statement to verify one or more eligibility factors when there is:

(a) a reasonable explanation as to why documentary verification or a collateral contact is not readily available to establish the factors; and

(b) the applicant/recipient's statement does not contradict other credible information received by the caseworker; in such instances where the statement contradicts the other information, the caseworker may require additional verification within a reasonable time after approval and authorization of assistance: an applicant/recipient who objects to such an additional request for information shall have the right to request and receive a fair hearing.

(2) A sworn statement is defined as the applicant/recipient's statement signed under penalty of perjury.

[8.100.130.9 NMAC - Rp, 8.100.130.9 NMAC, 08/01/2008]

8.100.130.10 SELECTION OF VERIFICATION: Verification shall be requested only when necessary to establish a specific eligibility factor or benefit amount for a program. The method of verification which is selected to establish eligibility on a factor is determined through discussion between the caseworker and the applicant/recipient.

A. Only necessary verification: The caseworker shall only request verification which is necessary to establish eligibility or benefit amounts for the assistance program(s) for which the applicant/recipient has applied.

B. Ready availability: The determination that verification is readily available will be made through discussion with the applicant/recipient. A readily available document is one which can be obtained by the applicant/recipient within five working days and at no cost to the applicant/recipient.

C. Verification of a negative statement: Verification, other than by sworn statement, of a negative statement shall not be required unless the statement is or becomes questionable as defined in 8.100.130.12 NMAC and at least one specific method of verifying the statement is readily available. A negative statement is a statement by an applicant/recipient that something does not exist or did not occur. Negative statements may be discussed with

the applicant/recipient depending on the applicant/recipient's circumstances.

D. Verifying more than one factor: To the extent possible, the caseworker shall use a document to establish more than one eligibility factor.
[8.100.130.10 NMAC - Rp, 8.100.130.10 NMAC, 08/01/2008]

8.100.130.11 TIMEFRAME FOR PROVISION OF VERIFICATION: An applicant/recipient is always allowed the complete time processing deadline for the program to provide necessary verification. The minimum amount of time allowed is specific to the program. This requirement pertains to requests for verification for initial applications as well as for verification for ongoing eligibility. Below are the time frames for provision of verification by type of assistance. The caseworker shall make an eligibility decision within three work days of the receipt of all necessary verification.

A. Food assistance and NMW/EWP cash assistance programs: The application disposition deadline for the food stamp and cash assistance programs is 30 calendar days.

(1) Expedited (emergency) food stamps: If applicant is eligible for expedited food stamp processing, issue benefits no later than the sixth day following the date of application to be available to the applicant/recipient on the seventh day or the preceding work day if the sixth day falls on a weekend or holiday.

(2) Day 1: Calendar day following date of application.

(3) Approvals: If verification provided establishes eligibility and the 30th calendar day after the application is:

(a) Monday by the preceding Friday, the 27th day;

(b) Tuesday by the preceding Monday, the 29th day;

(c) Wednesday by the preceding Tuesday, the 29th day;

(d) Thursday by the preceding Wednesday, the 29th day;

(e) Fridayby the preceding Thursday, the 29th day;

(f) Saturday by the preceding Friday, the 29th day;

(g) Sunday by the preceding Friday, the 28th day;

(h) Monday holiday by the preceding Friday, the 27th day;

(i) if necessary verification is not received by these deadlines but is received on or before the end of the processing period, approve on the day that full verification is provided.

(4) Need-based determination: If verification provided establishes eligibility, ineligibility or justification for reduced benefits, approve, deny, or approve reduced benefits, no later than the 30th day after the application date, by the preceding work day if the 30th day falls on a weekend or holiday.

(5) Procedural denials:

(a) Lack of verification: If verification needed to determine eligibility is not provided and no extension of time is requested, deny on the 30th day after the application date or by next work day if 30th day falls on weekend or holiday.

(b) Missed interview: Make eligibility decision on the 30th day after the application date or by next work day if 30th day falls on weekend or holiday if applicant missed interview and did not reschedule interview.

(6) Extension of time beyond the 30th day: Make eligibility decision no later than the 60th day after the application date if the applicant requests one or more 10-day extensions of time to provide needed verification. There may only be three 10-day extensions.

(7) Reconsidering denials for refusal to provide verification or to complete application process: If an applicant/recipient has been denied benefits for refusal to provide needed verification or to complete the application process, but takes the required action within 30 days after the date of denial, the caseworker shall then make a needs-based decision.

B. Medical assistance: The application disposition deadline for medical assistance programs is 45 days from the date of application.

(1) Day 1: The date of application is the first day.

(2) No later than day 44 by the preceding work day if day 44 falls on a weekend or holiday:

(a) if verification provided establishes eligibility or ineligibility; or

(b) if the day following day 44 is not a work day, then decision must be made earlier than day 44 to allow for mailing on or before the deadline.

(3) No later than day 45 by the next work day if day 45 falls on a weekend or holiday, if needed verification is not provided until day 42 - 44.

(4) Day 45 by the next work day if day 45 falls on a weekend or holiday, if needed verification is provided on day 45, or is not provided.

(5) After day 45:

(a) When an applicant/recipient requests one or more 10-day extensions of time to provide needed verification. An applicant/recipient is entitled to receive up to three 10-day extensions of time upon request.

(b) The eligibility decision must be made as soon as possible and within three work days of receipt of all necessary verification.

C. General assistance: An application for general assistance shall be processed no later than 60 days from the date the application is filed.

(1) No later than day 59: by the previous work day if day 59 falls on a weekend or holiday:

(a) if verification provided establishes eligibility or ineligibility; or

(b) if day following day 59 is not a work day, then decision must be made earlier than day 59 to allow for mailing on or before deadline.

(2) No later than day 60 by the next work day if day 60 falls on a weekend or holiday, if needed verification is not provided until day 57 - 59.

(3) Day 60 by the next work day if day 60 falls on a weekend or holiday, if needed verification is provided on day 60, or is not provided.

(4) After day 60:

(a) When an applicant/recipient requests one or more 10-day extensions of time to provide needed verification. An applicant/recipient is entitled to receive up to three 10-day extensions of time upon request.

(b) The eligibility decision must be made as soon as possible and within 3 work days of receipt of all necessary verification.

(5) Tracking the application processing time limit: The application processing time limit begins on the day after the signed application is received in the ISD county office.

(6) Delayed determination: If an eligibility determination is not made within the required application processing time limit, the applicant/recipient shall be notified in writing of the reason for the delay and that the applicant/recipient has the right to request a fair hearing regarding ISD's failure to act within the time limits.

(7) Extensions of time: Up to three 10 calendar day extensions for providing verification shall be granted at the applicant/recipient's request. The extension begins at the end of the application processing time period or at the end of the previous extension.

(8) GA disability determination delayed: The application for GA for disabled adults shall remain in pending status until a disability determination is made either by the caseworker or the incapacity review unit. The application shall be processed by the county office no later than three working days after the caseworker makes the eligibility determination or the county office receives notification of a disability determination from the incapacity review unit.
[8.100.130.11 NMAC - Rp, 8.100.130.11 NMAC, 08/01/2008]

8.100.130.12 QUESTIONABLE INFORMATION/VERIFICATION:

A. To be considered questionable, incomplete or inadequate, the information or verification must be documented as one of the following:

(1) inconsistent with statements made by the applicant/recipient;

(2) inconsistent with other information on the application or previous applications;

(3) inconsistent with credible information received by the department;

(4) questionable on its face.

B. Resolving questionable information: Upon receiving questionable, incomplete or inadequate verification needed to determine an applicant/recipient's eligibility or benefit amount, the caseworker shall promptly provide the applicant/recipient a notice which shall include the following:

(1) advise the applicant/recipient of the receipt of the information;

(2) why it is questionable, incomplete or inadequate;

(3) the additional information that must be provided;

(4) the alternative methods of providing the information,

(5) the deadline for supplying the information (10 working days or the end of the applicable application processing time period, whichever is later);

(6) that the applicant/recipient will be allowed an extension of time to supply the information if requested;

(7) that the applicant/recipient should contact the caseworker if an extension is desired;

(8) that the applicant/recipient may discuss with the caseworker whether any other readily available verification is acceptable;

(9) that the caseworker is available to assist the applicant/recipient if the information is not readily available; and

(10) that a failure to supply the needed information or contact the caseworker by the deadline may result in a delay, a denial of eligibility or a reduction in the amount of benefits.

[8.100.130.12 NMAC - Rp, 8100.130.12 NMAC, 08/01/2008]

8.100.130.13 NON-FINANCIAL VERIFICATION STANDARDS - IDENTITY:

A. Food stamp and cash assistance programs: Verification of identity for the applicant is mandatory at application for the food stamp and cash assistance programs. Documents that can be used to verify identity for the food stamp and cash assistance programs include, but are not limited to:

(1) photo ID; including driver's license;

(2) birth certificate;

(3) school record;

(4) church record;

(5) hospital or insurance card;

(6) letter from community resources;

(7) voter registration card;

(8) work ID;

(9) ID for another assistance or social service program;

(10) wage stubs;

(11) additional items as listed in ISD 135, "proof checklist"; or

(12) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

B. Medical assistance programs: Verification of citizenship and identity for the applicant/recipient is mandatory at initial application and recertification on or after July 1, 2006. The applicant/recipient is required to submit an original or a copy certified by the issuing agency.

(1) Exemptions: The following individuals are exempt from providing documentation of citizenship and identity:

(a) individuals receiving supplemental security income benefits under Title XVI of the Social Security Act;

(b) individuals entitled to or enrolled in any part of medicare;

(c) individuals receiving social security disability insurance benefits under section 223 of the Social Security Act or monthly benefits under section 202 of the act, based on the individual's disability, as defined in section 223(d) of the act;

(d) individuals who are in foster care and who are assisted under Title IV-B of the Social Security Act; or

(e) individuals who are recipients of foster care maintenance or adoption assistance payment under Title IV-E of the act.

(2) Documents that verify both citizenship and identity:

(a) U.S. passport (active or expired);

(b) certificate of U.S. citizenship (DHS form N-560 or N-561); or

(c) certificate of naturalization (DHS form N-550 or N-570).

(3) Documents to verify identity. The following documents may be accepted as proof of identity and must accompany a document establishing citizenship from the second, third or fourth level documents. See Paragraphs (1) (2) and (3) of Subsection B of 8.100.130.16 NMAC:

(a) a current state driver's license from a state or territory with the individual's picture or other identifying information such as name, age, sex, race, height, weight, or eye color;

(b) school identification card with a picture of the individual;

(c) U.S. military card or draft record;

(d) identification card issued by the federal, state or local government with the same information included on the driver's license;

(e) military dependent's identification card;

(f) certificate of degree of Indian Blood, or other American Indian/Alaska native tribal document with a picture or other personal identifying information, such as age, weight, height, race, sex, and eye color;

(g) Native American tribal document with a picture or other personal identifying information, such as age, weight, height, race, sex and eye color;

(h) U.S. coast guard merchant mariner card;

(i) a cross match with federal or state governmental, public assistance, law enforcement or corrections agency's data systems, if the agency establishes and certifies the true identity of the individual;

(j) three or more corroborating documents, such as marriage licenses, divorce decrees, high school diplomas, and employer identification cards may be used to verify the identity of an individual when used in conjunction with level two or three citizen documentation listed at 8.100.130.16 NMAC; these documents must contain the applicant/recipient' name and additional information to establish identity; all documents must contain consistent identifying information.

(4) Special rules for verifying proof of identity for children 16 or younger:

(a) school records verified from the school, including report card, daycare or nursery school record;

(b) clinic, doctor or hospital record;

(c) an affidavit signed under penalty of perjury by a parent, guardian or relative caretaker stating the date and place of birth of the child:

(i) An affidavit can only by used if one of the preceding documents is not available.

(ii) An affidavit cannot be used if an affidavit for citizenship was used.

(5) An identity affidavit signed under penalty of perjury by a residential facility director or administrator on behalf of the institutionalized applicant/recipient.

[8.100.130.13 NMAC - Rn, 8.100.130.13 NMAC, 08/01/2008]

8.100.130.14 NON-FINANCIAL VERIFICATION STANDARDS: NON-CONCURRENT RECEIPT OF ASSISTANCE:

A. Verification of nonconcurrent receipt of assistance is mandatory. The caseworker has responsibility for verifying nonconcurrent receipt of benefits usually through government data systems or other state agencies.

(1) For food stamp purposes, non receipt of food stamp benefits from this state or another state or receipt of tribal commodities must be verified.

(2) For medicaid, ineligibility to receive medicaid benefits from this state or another state in the current month must be verified.

(3) For cash assistance, ineligibility for and non receipt of assistance from the supplemental security income (SSI) program and bureau of Indian affairs general assistance (BIA GA) program, TANF assistance from New Mexico tribal programs, cash assistance from a HSD administered program and adoption subsidies funded through Title IV-E of the Social Security Act must be verified.

B. Non-receipt of benefits from another state must be verified for applicants who indicate a recent move to New Mexico from another state and prior receipt of assistance from that state.

C. Methods which can be used to verify nonconcurrent receipt of assistance include:

(1) ISD2 for non-receipt of assistance from ISD programs;

(2) state data exchange (SDX) for non-receipt of SSI;

(3) contact with the New Mexico children, youth and families department for non-receipt of assistance;

(4) document from another state showing termination of benefits;

(5) collateral contact - oral statement from other state for termination of food stamps, TANF, or medicaid;

(6) collateral contact - oral statement from bureau of Indian affairs for non-receipt of BIA-GA; or

(7) collateral contact - oral statement from tribal TANF programs for non-receipt of tribal TANF

[8.100.130.14 - Rp, 8.100.130.13 NMAC, 08/01/2008]

8.100.130.15 NON FINANCIAL VERIFICATION STANDARD - ENUMERATION:

A. Verification that the enumeration requirement for an applicant/recipient has been met is mandatory. The applicant/recipient must provide the social security number (SSN) which has been issued to the individual no later than 60 days following approval. The caseworker shall verify the SSN through the following methods:

(1) When an SSN is provided: The SSN will be verified through a data match with the SSA. If the SSN is not validated through the data match, the following sources of verification listed below may be utilized to validate the SSN:

(a) ISD2 system validation;

(b) social security card (OA-702);

(c) ISD social security number validation report form (ISD 260);

(d) an original SSA document containing the SSN; or

(e) the individual who has provided their SSN will not be required to produce proof of SSN unless the SSN is found to be questionable.

(2) When an SSN is not provided: The applicant/recipient must provide verification of application for an SSN. The verification must indicate an application was made prior to approval of the individual for assistance. The verification shall be retained in the case record. Documents that can be used to verify an application for SSN include:

(a) SSA 2853 enumeration at birth form;

(b) signed and dated statement from the hospital showing enumeration at birth has been done;

(c) original SSA document showing an application for SSN has been made and accepted; or

(d) completed SS-5; the completed SS-5 must be dated and submitted prior to the date of approved; a copy of the completed and submitted SS-5 must be retained in the case record.

B. There is no requirement of enumeration for medicaid-newborn (Category 31).

[8.100.130.15 - Rp, 8.100.130.13 NMAC, 08/01/2008]

8.100.130.16 NON FINANCIAL VERIFICATION STANDARD-CITIZENSHIP AND ELIGIBLE ALIEN STATUS: This section details the specific types of documents to be used in establishing the applicant/recipient's citizenship and alien status for food assistance, cash assistance and medical assistance programs.

A. Citizenship for food stamp and cash assistance: Citizenship for food stamp and cash assistance programs will be verified only when questionable (as defined by manual section 8.100.130.12 NMAC). Documents that can be used to verify citizenship include:

(1) birth certificate;

(2) naturalization papers from the department of homeland security United States citizenship and immigration services (DHS) such as DHS Forms I-179 or I-197;

(3) U.S. passport;

(4) military service papers;

(5) hospital record of birth;

(6) baptismal record, when place of birth is shown;

(7) Indian census records;

(8) DHS 400 for alien children who can derive citizenship through citizen father or mother;

(9) additional items as listed on ISD 135, "proof checklist";

(10) any document listed in Paragraph B of this section; or

(11) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

B. Medical assistance programs: After July 1, 2006, an applicant for medical assistance programs must provide the income support division with a declaration signed under penalty of perjury that the applicant is a citizen or national of the United States. An alien applicant who declares to be in satisfactory immigration status is also required to continue to present immigration status documentation. Verification of citizenship for the applicant/recipient is mandatory at initial application and recertification on or after July 1, 2006. The applicant/recipient is required to submit original or a copy certified by the issuing agency.

(1) First level documents that verify both citizenship and identity:

(a) U.S. passport (active or expired);

(b) certificate of U.S. citizenship (DHS form N-560 or N-561); or

(c) certificate of naturalization (DHS form N-550 or N-570).

(2) Second level documents: These documents should only be used when first level documents are unavailable. The following are second level documents of citizenship:

(a) U.S. public birth certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico (if born on or after 1941, Guam (if born on or after April 10, 1899), the Virgin Islands of the U.S. (if born on or after January 17, 1917), American Samoa, Swain's Island or the Northern Mariana Islands (if born on or after November 4, 1986 NMI local time);

(i) data matches with a state vital statistics agency may be used in place of a birth certificate;

(ii) the birth record may be issued by the state, commonwealth, territory or local jurisdiction and it must have been recorded before the person was five years of age; a birth record that is recorded at or after the person is five years of age is considered fourth level evidence of citizenship;

(b) a certification of report of birth (SD-1350) issued by the department of

state to U.S. citizens who were born outside the U.S. and acquired U.S. citizenship at birth;

(c) a report of birth abroad of a U.S citizen (FS-240);

(d) a certification of birth issued by the department of state (FS-545): in 1990, the FS-545 was replaced by the SD-1350;

(e) a U. S. citizen I.D. card (DHS Form I-179 and I-197);

(f) a Northern Mariana identification card (I-873) issued by DHS to a collectively naturalized citizen of the U. S. who was born in the Northern Mariana Islands before November 4, 1986;

(g) an American Indian Card (I-872) issued by the DHS with the classification code "KIC," to identify U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border;

(h) final adoption decree with the child's name and U.S. place of birth;

(i) evidence of civil service employment by the U.S. government before June 1, 1976;

(j) U.S. military record of service showing a U.S. place of birth;

(k) a data verification with the SAVE program for naturalized citizens if conducted consistent with a memorandum of understanding with DHS; or

(l) adopted or biological children born outside of the U.S. may establish citizenship obtained automatically under section 320 of the Immigration and Nationality Act (8. U.S.C 1431) as amended by the Child Citizenship Act of 2000; documentary evidence shall be obtained confirming on or after February 27, 2001, the following conditions were met:

(i) at least one parent of the child is a U.S. citizen by birth or naturalization;

(ii) the child is under the age of 18;

(iii) the child is residing in the U.S. in the legal and physical custody of the U.S. citizen parent;

(iv) the child was admitted to the U.S. for lawful permanent residence pursuant to 8 U.S.C. 1641; and

(v) if adopted, the child satisfies the requirements of section 101(b)(1) of the Immigration and Nationality Act (8 U.S.C. 1101(b)(1)) pertaining to international adoptions.

(3) Third level documents: These documents should only be used when first and second level documents are unavailable; the following documents are third level documents of citizenship:

(a) Extract of a hospital record on hospital letterhead established at the time of the person's birth that was created five years before the initial application date and shows a U.S. place of birth. For children under the age of 16, the document must have been created near the time of birth or five years before the date of application.

(b) Life, health or other insurance record showing a U.S. place of birth and was created at least five years before the initial application date. For children under the age of 16, the document must have been created near the time of birth or five years before the date of application.

(c) An official religious record recorded with the religious organization in the U.S. within three months of birth showing the birth occurred in the U.S. and showing the date of birth or the individual's age at the time the record was made**;** if the place of birth is questionable, verification must be obtained that the mother was in the U.S. at the time of birth.

(d) Early school record showing a U.S. place of birth, date of birth, the name of the child, the date of admission to the school and the name and place of birth of the applicant/recipient's parents.

(4) Fourth level documents: These documents should only be used when first, second and third level documents are not available. With the exception of the affidavit process described in this section, the applicant/recipient may only use fourth level of evidence of citizenship if alleging a U.S place of birth. The following documents are fourth level documents of citizenship:

(a) federal or state census record showing U.S. citizenship or a U.S. place of birth and the applicant/recipient's age; or

(b) one of the following documents that shows a U.S. place of birth and that was created at least five years before the application for medicaid; for children under the age of 16, the document must have been created near the time of birth or five years before the date of application. These documents are:

(i) Seneca Indian tribal census record;

(ii) bureau of Indian affairs tribal census records of the Navajo Indians;

(iii) U.S. state vital statistics official notification of birth registration;

(iv) a delayed U.S. public birth record that is recorded more than five years after the person's birth;

(v) a statement signed by a physician or midwife who was in attendance at the time of birth.

(vi) the roll of Alaska natives maintained by the bureau of Indian affairs.

(c) institutional admission papers from a nursing facility, skilled care facility or other institution created at least five years before the initial application date that indicates a U.S. place of birth.

(d) medical (clinic, doctor, or hospital) record created at least five years before the initial application date that indicates U.S. place of birth; for children under the age of 16, the document must have been created near the time of birth or five years before the date of application; an immunization record is not considered a medical record for purposes of establishing citizenship.

(e) written affidavits should only be used in rare circumstances and must contain the following information:

(i) the applicant/recipient musts provide at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant/recipient's claim of citizenship;

(ii) at least one of the individuals making the affidavit cannot be related to the applicant/recipient and neither can be the applicant/recipient;

(iii) individuals making the affidavit must prove their own citizenship and identity; and

(iv) if available, the affidavit should contain why documentary evidence establishing the applicant/recipient's claim of citizenship does not exist or cannot be readily obtained;

(v) the applicant/recipient or other knowledgeable individual (guardian or representative) must submit a separate affidavit explaining why the evidence does not exist or cannot be obtained; or

(vi) the affidavits must be signed under penalty of perjury and need not be notarized.

C. Alien status: A alien must have a valid department of homeland security U.S. citizenship and immigration services document.

D. Systematic alien verification for entitlement (SAVE)

(1) All applicants who indicate eligible alien status will be subject to verification through the United States department of homeland security's (USDHS) database (SAVE) system.

(2) Conflicting information regarding the alien status provided by the applicant/recipient will require additional verification by the USDHS.

[8.100.130.16 - Rp, 8.100.130.13 NMAC, 08/01/2008]

8.100.130.17 NON FINANCIAL VERIFICATION STANDARDS - RESIDENCE:

A. Verification of New Mexico residence is mandatory. Residence may be verified by the use of documentary evidence provided for other eligibility crite-

ria.

B. Documents that can be used to verify residency include:

(1) rent or mortgage receipt;
(2) statement from landlord;
(3) utility bills;
(4) statement from an employer;
(5) employment records;
(6) tax office records;
(7) post office records;
(8) church or synagogue records;
(9) utility company records;
(10) school records;
(11) proof of ownership of property;
(12) current driver's license;
(13) canceled letters;
(14) additional items as listed on ISD 135, "proof checklist"; or
(15) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC

[8.100.130.17 - Rp, 8.100.130.13 NMAC, 08/01/2008]

8.100.130.18 NON FINANCIAL VERIFICATION STANDARDS - HOUSEHOLD COMPOSITION:

A. The applicant/recipient's statement regarding household composition will be accepted.

B. Household composition will only be verified when determined questionable as defined by 8.100.130.12 NMAC. Documents that may be used to verify household composition include:

(1) lease agreement listing household members;
(2) landlord's written statement of household composition;
(3) additional items as listed on ISD 135, "proof checklist"; or
(4) if documentary evidence is not readily available, use other methods of verification as in 8.100.130.9 NMAC.

[8.100.130.18 - Rp, 8.100.130.13 NMAC, 08/01/2008]

8.100.130.19 NON FINANCIAL VERIFICATION STANDARDS - AGE:

A. Age of child: Verification of age of children is mandatory for cash and medical assistance for children programs.

(1) For cash assistance: Age of the child is verified prior to approval.

(2) For medical assistance for children: Age of the child is verified to determine if the child is under the specified age limit**.**

B. Age of adults: Age of adult members is verified in the following circumstances if age is questionable:

(1) Food stamps:

(a) if the individual is claiming a medical deduction on the basis of age (60 and over); or

(b) if the individual is working and income is being disregarded due to age (under age 18).

(2) Cash assistance:

(a) if the parent/caretaker relative is being considered for work program participation on the basis of being a minor parent and the parent claims to be age 20 or over;

(b) if the parent is living in his/her parent's home and is claiming emancipation on the basis of age (18 or over);

(c) if the parent/caretaker relative is not living in his/her parents' home and cooperation with child support enforcement is an issue due to age of the specified relative (under 18); or

(d) if the caretaker relative, parent or other adult member claims exemption from work program participation requirements based on age (60 and over).

(3) General assistance for the disabled:

(a) if the individual is claiming to be 18 or over and evidence is to the contrary; or

(b) if the individual is claiming to be under age 65 and evidence is to the contrary.

(4) Medical assistance for pregnant women:

(a) if the pregnant woman is living in her parent's home and is claiming emancipation on the basis of age (18 or over); or

(b) if the pregnant woman is under the age of 18 and is not living in her parents' home and cooperation with child support enforcement is an issue.

(5) Documents that can be used to verify age include:

(a) birth certificate;
(b) adoption papers or records;
(c) hospital or clinic records;
(d) church records;
(e) baptismal certificate;
(f) bureau of vital statistics records;
(g) U.S. passport;
(h) Indian census records;
(i) local government records;
(j) immigration and naturalization records;
(k) social security records;
(l) school records;
(m) census records;
(n) court support order;
(o) physician's statement;
(p) juvenile court records;
(q) voluntary social service agency records;
(r) insurance policy;
(s) minister's signed statement;
(t) military records;
(u) driver's license;
(v) additional items as listed on ISD-135, "proof checklist"; or
(w) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

[8.100.130.19 - Rp, 8.100.130.13 NAMC, 08/01/2008]

8.100.130.20 NON FINANCIAL VERIFICATION STANDARD - SCHOOL ATTENDANCE:

A. Verification of school attendance for all children age 6 and older is mandatory for the cash assistance program.

B. Documents that can be used to verify school attendance include:

(1) written statement from school official;
(2) current report card;
(3) additional items as listed on ISD 135, "proof checklist"; or
(4) if the preceding documentary evidence is not readily available, other acceptable methods of verification are set forth in 8.100.130.9 NMAC.

[8.100.130.20 - Rp, 8.100.130.13 NMAC, 08/01/2008]

8.100.130.21 NON FINANCIAL VERIFICATION STANDARD - RELATIONSHIP:

A. Verification of relationship is mandatory in the cash assistance program. The relationship between the parent or other caretaker relative and each child included in the benefit group must be verified.

B. Documents that can be used to verify relationship include:

(1) birth certificate;
(2) adoption papers or records;
(3) Indian census records;
(4) bureau of vital statistics or local government records;
(5) DHS records;
(6) hospital or public health records of birth and parentage;
(7) baptismal records;
(8) marriage certificate showing legal marriage between parents;
(9) court records of parentage such as support orders, divorce decrees, etc.;
(10) juvenile court records;
(11) paternity records from CSED;
(12) ISD acknowledgment of paternity form;
(13) CSED acknowledgment of paternity packet for alleged or non-court ordered determined parents living with children;
(14) church records including a statement from a priest, minister, etc.;
(15) additional items as listed on ISD 135, "proof checklist"; or
(16) if documentary evidence is

not readily available, use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

C. The documentary evidence must contain the names of both the child and the specified relative. When the last name of the child differs from the specified relative, the difference must be resolved and documented in the case record. Divorce papers or marriage licenses can be used to help establish the relationship when the child's last name differs from the last name of the specified relative.

(1) If the relative is other than a parent, the relationship must be traced.

(2) In situations involving both parents in the home and the father is not the legal father, where paternity has not been established by operation of law or determined through court order, it will be necessary to establish the relationship of the child to the father by completion of the CSED acknowledgment of paternity packet.

(3) If the child is living with a relative of the alleged father, it will also be necessary to establish the father-child relationship. The preferred method of proving the relationship will be through acknowledgment of paternity, although other documents will be acceptable means of establishing relationship.

[8.100.130.21 - Rp, 8.100.130.13, NMAC, 08/01/2008]

8.100.130.22 NON FINANCIAL VERIFICATION STANDARDS - OTHER:

A. Fraud conviction for dual state receipt of benefits: The existence of a fraud conviction for simultaneous receipt of benefits from two states is determined based upon client statement on the application form. If the caseworker receives other information indicating the existence of a dual state benefit fraud conviction, the caseworker shall verify it by contacting the appropriate authorities.

B. Fleeing felon and probation or parole violator: Whether an individual is a fleeing felon or a probation or parole violator is determined based upon a client statement on the application form. If the caseworker receives other information indicating that the individual is a fleeing felon, the caseworker shall verify it by contacting appropriate authorities. The caseworker need not notify the individual of the report, nor request his or her permission to verify the information with appropriate law enforcement agencies.

[8.100.130.22 - Rp, 8.100.130.13 NMAC, 08/01/2008]

8.100.130.23 FINANCIAL VERIFICATION STANDARDS - RESOURCES: The applicant/recipient's statement is acceptable for verification of resources unless the household is near the resource maximum limit and the information given is not questionable. If information is questionable, inconsistent or the household is near the maximum; the caseworker must clearly document why the household's statement was unacceptable in the case record and it requires additional verification. When further information or verification is requested the following items shall be acceptable:

A. Bank accounts (checking, savings, certificates of deposit, savings bond, or Keogh's). Documents which may be used to verify bank or financial institution accounts include:

(1) current bank statement;

(2) statement from the bank or institution showing the value of the resource or the penalties for early withdrawal of deposit showing the total value and the penalty for early withdrawal;

(3) savings bond(s) showing total value and statement from bank/institution of penalty for early withdrawal;

(4) additional items as listed in ISD 135, "proof checklist"; or

(5) if documentary evidence is not readily available, use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

(6) joint bank accounts: see appropriate program chapter for proper verification requirements.

B. Stocks and bonds: Documents which may be used to verify the value of stocks or bonds include:

(1) newspaper publications of the stock exchange;

(2) statement from the stock broker;

(3) additional items as listed in ISD 135, "proof checklist"; or

(4) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

C. Life insurance: Documents which may be used to verify the cash surrender value of life insurance include:

(1) insurance policy;

(2) statement from the insurance company, insurance agent, lodges or fraternal organizations;

(3) statement from the union or employer who provide the insurance;

(4) statement from the veteran's administration;

(5) additional items as listed in ISD 135, "proof checklist"; or

(6) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC;

(7) if the cash surrender value of the life insurance policy makes the applicant/recipient ineligible, liens against the insurance shall be explored; this will be done through use of acceptable methods of verification set forth in 8.100.130.9 NMAC; the cash surrender value of life insurance is necessary in programs only where it is countable.

D. Real estate contracts, purchase contracts: Documents which may be used to verify the value of real estate or purchase contracts include:

(1) statement from a bank or financial institution, commodity broker, real estate agent, or expert in the field of real estate contracts or purchase contracts;

(2) additional items as listed in ISD 135, "proof checklist"; or

(3) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

E. Non-recurring lump sum payment: Documents which may be used to verify a nonrecurring lump-sum payment include:

(1) statement from a company, agency or organization that provided payment;

(2) copy of a check or check stub;

(3) award letters;

(4) statement from an attorney;

(5) additional items as listed in ISD 135, "proof checklist"; or

(6) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

F. Tools and equipment: Documents which may be used to verify the value of tools and equipment include:

(1) recent sales slips;

(2) insurance or tax appraisals;

(3) catalogs or newspaper ads;

(4) statement from a bank, broker, local merchant or expert on tools and equipment;

(5) additional items as listed in ISD 135, "proof checklist"; or

(6) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

G. Real property: Documents which may be used to verify the value of real property the applicant/recipient does not use include:

(1) a written statement from a real estate agent or broker stating the fair market value of property;

(2) statement from a bank or financial institution stating value and equity;

(3) additional items as listed in ISD 135, "proof checklist"; or

(4) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.
[8.100.130.23 - Rp, 8.100.130.14 NMAC, 08/01/2008]

8.100.130.24 FINANCIAL VERIFICATION STANDARDS - UNEARNED INCOME: Verification of income is mandatory for all programs.

A. Social security benefits (OASDI, SSI): Documents which may be used to verify OASDI/SSI benefits include

(1) award letter (Form SSA 1610);

(2) copy of a check(s) - amount of medicare premium must be added in;

(3) letter from SSA;

(4) direct deposit receipt - amount of medicare premium must be added in;

(5) additional items as listed in ISD 135, "proof checklist"; or

(6) if documentary evidence is not readily available or is questionable, a collateral contact with the social security administration (TPQY) may be selected as verification of OASDI/SSI or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

B. Veteran's benefits: Documents which may be used to verify veteran's benefits include:

(1) award letter;

(2) copy of a check(s);

(3) written verification from a regional VA office;

(4) direct deposit receipt(s);

(5) additional items as listed in ISD 135, "proof checklist"; or

(6) if documentary evidence is not readily available or is questionable, a collateral contact with the veteran's administration may be selected as verification of veteran's benefits use other acceptable methods of verification as in 8.100.130.9 NMAC.

C. Railroad retirement benefits: Documents which may be used to verify railroad retirement benefits include:

(1) award letter;

(2) copy of a check;

(3) letter from SSA;

(4) direct deposit receipt;

(5) additional items as listed in ISD 135, "proof checklist"; or

(6) if documentary evidence is not readily available or is questionable, a collateral contact with the regional director of retirement claims may be selected as verification of railroad retirement benefits or use acceptable methods of verification as in 8.100.130.9 NMAC.

D. Military allotments: Documents which may be used to verify military allotment include:

(1) written statement from the appropriate military service center;

(2) copy of the allotment authorization;

(3) copy of a check;

(4) direct deposit receipt;

(5) additional items as listed in ISD 135, "proof checklist"; or

(6) if documentary evidence is not readily available or is questionable, a collateral contact with the appropriate military service center may be selected as verification of a military allotment or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

E. Workers' compensation benefits: Document which may be used to verify worker's compensation includes:

(1) employer's statement;

(2) written statement from workers' compensation administration;

(3) written statement from insurance company;

(4) additional items as listed in ISD 135, "proof checklist"; or

(5) if documentary evidence is not readily available or is questionable, a collateral contact with the New Mexico department of workforce solutions (NMDWS) or with the insurance company may be selected as verification of workers' compensation benefits or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

F. Unemployment compensation benefits (UCB): Verification of unemployment compensation benefits should first be explored through the NMDWS web link. If it is not available through the NMDWS web link, the following documents may be used to verify UCB include:

(1) award letter;

(2) copy of a check;

(3) statement from the New Mexico DWS;

(4) additional items as listed in ISD 135, "proof checklist"; or

(5) if documentary evidence is not readily available, a collateral contact with the NMDWS may be selected as verification of unemployment compensation benefits or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

G. Child/spousal support: Verification of child or spousal support should first be explored through the CSED automated system If it is not available through the CSED system, documents which may be used include:

(1) written statement from the contributor;

(2) written statement from the court;

(3) copy of a check or a canceled check;

(4) divorce or separation decree;

(5) court order;

(6) support agreement;

(7) correspondence from the contributor regarding support payments;

(8) court records';

(9) attorney's records;

(10) income tax return from the prior year;

(11) employer's record of attached wages;

(12) additional items as listed in ISD 135, "proof checklist"; or

(13) if documentary evidence is not readily available or is questionable, a collateral contact may be selected to verify child/spousal support or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC;

(14) no contact with the absent parent shall be made without the consent of the applicant/recipient. If good cause for failure to cooperate with CSED has been filed, contact with the absent parent must not be made.

H. Educational scholarships, grants or loans: Documents which may be used to verify amounts of an educational scholarship, grant, or loan include:

(1) financial aid award letter or a budget sheet from the institution;

(2) written statement from the institution;

(3) written statement from veteran's administration;

(4) additional items as listed in ISD 135, "proof checklist";

(5) as educational expenses are deducted from the educational scholarship, grant or loan, it will be necessary to obtain verification of the expenses; verification may be obtained from the institution; or

(6) if documentary evidence is not readily available or is questionable, a collateral contact with the institution may be selected as verification of an education scholarship, grant or loan or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

I. Non-recurring lump sum: See Subsection E of 8.100.130.23 NMAC.

J. Contributions: Documents which may be used to verify contributions include:

(1) written statement from the contributor;

(2) additional items as listed in ISD 135, "proof checklist"; or

(3) if documentary evidence is not readily available or is questionable, a collateral contact with the contributor may be selected as verification of a contribution or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

K. Loans: Verification of

a loan must contain the name of the person making the loan, the amount of the loan, date the loan was made and the repayment arrangement for the loan. Documents which may be used to verify loans include:

(1) written statement from the person or organization making the loan;

(2) promissory note;

(3) loan agreement;

(4) additional items as listed in ISD 135, "proof checklist"; or

(5) if documentary evidence is not readily available or is questionable, a collateral contact with the person or organization making the loan may be selected as verification of a loan or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

L. Individual development accounts (IDA)

(1) The IDA is verified by reviewing the trust documents creating the IDA and documents verifying deposits and withdrawals from the account during the period since the previous certification. The trust documents must show the terms and conditions governing the IDA, including withdrawal provisions.

(2) The caseworker shall review deposits and withdrawals to ensure that no funds are being withdrawn except for those allowed under IDA policy and to ensure that the individual was employed during the time that any deposits were made.

[8.100.130.24 NMAC - Rp, 8.100.130.14 NMAC, 08/01/2008]

8.100.130.25 FINANCIAL VERIFICATION STANDARDS - EARNED INCOME:

A. Wages and salaries: Documents which may be used to verify current wages and salaries include:

(1) wage stubs;

(2) written statement from the employer;

(3) additional items as listed in ISD 135, "proof checklist"; or

(4) if documentary evidence is not readily available or is questionable, a collateral contact with the employer may be selected as verification of wages and salaries or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

B. Self-employment: Verification of required tax and employer identification numbers, and tax-related and employer-related forms that the applicant/recipient was required to file is mandatory. It may not be possible to verify self-employment income through any single document. Documents which are used to verify self-employment income include:

(1) required state and federal tax and employer identification numbers;

(2) required federal and state tax forms for the current and prior tax year, including state and federal income and employer wage reporting and withholding reporting forms, gross receipts and occupation tax reporting forms;

(3) bills which indicate self-employment costs;

(4) other papers showing income and business expenses;

(5) all required business and occupation licenses;

(6) completed personal wage record;

(7) additional items as listed in ISD 135, "proof checklist"; or

(8) if documentary evidence of non-mandatory documents is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

[8.100.130.25 NMAC - Rp, 8.100.130.14 NMAC, 08/01/2008]

8.100.130.26 DEDUCTIONS/ALLOWANCES VERIFICATION STANDARDS - SHELTER:

A. The applicant/recipient's statement is acceptable for verification of shelter expenses, if the information given is not questionable. If information is questionable or inconsistent; the caseworker must clearly document why the household's statement was unacceptable and what information requires additional verification. When further information or verification is requested the following items shall be acceptable:

(1) An obligation to pay for shelter is considered a deduction in the food stamp program. If the expense is questionable and verification of a shelter expense is requested and not provided, food stamp benefits will be determined without allowing a deduction for shelter expenses. When further verification is requested, documents which may be used to verify an obligation to pay for shelter include:

(a) mortgage payment book;

(b) written statement from the bank or other financial institution;

(c) rent receipt;

(d) written statement from the landlord;

(e) lease agreement;

(f) copies of bills for property taxes or house insurance;

(g) correspondence with the taxing authority or insurance agency; or

(h) additional items as listed on ISD 135 "proof checklist".

(2) If documentary evidence is not readily available or is questionable, a collateral contact may be selected to verify the obligation to pay shelter or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

B. Utilities: The applicant/recipient's statement is acceptable for verification of utility expenses, if the information given is not questionable. If information is questionable or inconsistent; the caseworker must clearly document why the household's statement was unacceptable and what information requires additional verification. Documents which may be used to verify an obligation to pay for utilities include:

(1) utility bills;

(2) rent receipt, lease agreement, or written statement from the landlord showing the household is responsible for payment of utilities;

(3) written statement from a utility provider;

(4) additional items as listed on ISD 135 "proof checklist"; or

(5) if documentary evidence is questionable, a collateral contact with the landlord or the utility provider may be selected to verify the obligation to pay for utilities or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

[8.100.130.26 NMAC - Rp, 8.100.130.15 NMAC, 08/01/2008]

8.100.130.27 DEDUCTIONS/ALLOWANCES VERIFICATION STANDARDS- MEDICAL EXPENSES:

A. Verification of medical expenses is mandatory for the food stamp program if the applicant/recipient meets one of the criteria listed below. The applicant/recipient's statement that no reimbursement will be received will be accepted unless questionable. If the household claims a reimbursement, a deduction cannot be allowed until the un-reimbursed portion of the expense is verified.

(1) the individual claiming the medical expense is age 60 or older or disabled; and

(2) the amount of the medical expenses exceeds $35; or

(3) allowance of the medical expenses would potentially result in a deduction;

(4) failure to provide verification of medical expenses will result in a determination of eligibility and amount of benefits without considering medical expenses.

B. Documents which may be used to verify a medical expense include:

(1) current bill;

(2) monthly statement from the provider;

(3) medical insurance policy;

(4) appointment cards, travel receipts (lodging and transportation) to verify travel costs associated with obtaining medical care;

(5) additional items as listed in ISD 135 “proof checklist”; or

(6) if documentary evidence is questionable, a collateral contact with the landlord or the utility provider may be selected to verify the obligation to pay for utilities or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

[8.100.130.27 NMAC - Rp, 8.100.130.15 NMAC, 08/01/2008]

8.100.130.28 DEDUCTIONS/ALLOWANCES VERIFICATION STANDARDS - DEPENDENT CARE:

A. The applicant/recipient’s statement is acceptable for verification of dependent care expenses, if the information given is not questionable. If information is questionable or inconsistent; the caseworker must clearly document why the household’s statement was unacceptable and why information requires additional verification.

B. Documents which may be used to verify dependent care costs:

(1) current bill;

(2) written statement from the provider;

(3) additional items as listed in ISD 135 “proof checklist”; or

(4) if documentary evidence is not readily available, or is questionable a collateral contact with the care provider may be used as verification of dependent care costs or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

[8.100.130.28 NMAC - Rp, 8.100.130.15 NMAC, 08/01/2008]

HISTORY OF 8.100.130 NMAC:

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

ISD Rule 160, Eligibility and Verification Standards, 2/9/88.

ISD Rule 160, Eligibility and Verification Standards, 9/15/93.

History of Repealed Material:

8 NMAC 3.ISD.130, General Operating Policies, Eligibility/Verification Standards, filed 6/16/97 - Repealed, 7/1/97.

8.100.130 NMAC, General Operating Policies - Eligibility and Verification Standards, filed 3/26/2001 - Repealed, 8/1/2008

NEW MEXICO HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

This is an amendment to 8.139.110 NMAC, Section 11, effective August 1, 2008.

8.139.110.11 INTERVIEWS

A. Purpose and scope of interview: The interview is an official and confidential discussion of household circumstances with the applicant. It is intended to provide the applicant with program information, and the worker with the facts needed to make a reasonable eligibility determination. The interview is not simply to review the information on the application, but also to explore and clarify any unclear and incomplete information. The scope of the interview shall not extend beyond examination of the applicant’s circumstances that directly relate to determining eligibility and benefit amounts. The interview shall be held prior to disposition of the application.

B. Joint cash assistance/food stamp interview: At initial application for cash assistance (CA), a single interview shall be conducted concurrently for both cash assistance and food stamp benefits if the client wishes to apply for both programs. Federal food stamp regulations specifically provide that applicants for both programs shall not be required to see a different caseworker or be otherwise subjected to two interviews in order to obtain the benefits of both programs. Following the single interview, the application may be processed by separate workers to determine eligibility for food stamp benefits and cash assistance. In an expedited food stamp certification situation, a second interview is permitted if an immediate interview for cash assistance cannot be arranged.

C. Individuals interviewed: Applicants, including those who submit applications by mail, shall be interviewed in person at the local ISD office. When circumstances warrant, the household shall be interviewed by telephone, or at another place reasonably accessible and agreeable to both the applicant and the caseworker. The applicant may bring any person he chooses to the interview.

D. Out of office interviews:

(1) A food stamp applicant shall not be required to have an initial office interview if the applicant is unable to appoint an authorized representative and the household has no member(s) able to come to the food stamp office because the member(s) is elderly or disabled, as defined.

(2) The initial office interview can also be waived if requested by any household that is unable to appoint an authorized representative who is willing and able to perform this function, and who lives in a location not served by a certification office. [~~The county director may also waive the office interview on a case-by-case basis as circumstances warrant.~~]

[~~**(3) Hardship conditions:** The office interview shall also be waived when no household member is able to come to the office because of transportation difficulties or similar hardship. Hardship conditions include, but are not limited to, illness, care of a household member, residence in a rural area, prolonged severe weather, or work or training hours that prevent the household from attending an office interview.~~]

(3) Hardship conditions: The office interview for food stamp households shall be waived when the applicant meets one of the following conditions:

(a) over the age of 60;

(b) disabled;

(c) employed 20 or more hours per week;

(d) has a dependent child under the age of 6;

(e) has transportation difficulties;

(f) illness;

(g) care of a household member;

(h) resides in a rural area;

(i) prolonged severe weather;

(j) other hardship identified as situations warrant; as authorized by the county director.

(4) A face-to-face interview must be granted to any recipient who requests one.

E. Face-to-face/telephone interviews: A household shall have a face-to-face interview at initial certification and at least once every 12 months thereafter.

(1) A household certified for longer than 12 months is excluded.

(2) At recertification, a household is considered to have met the face-to-face requirement when alternative recertification interviews are conducted by telephone.

(3) No household shall have the face-to-face interview waived for two consecutive recertifications.

F. Applicant information: During the application interview all reasonable steps shall be taken to make the applicant feel at ease and protect the applicant’s right to privacy.

(1) Providing information: The caseworker shall explain all program information and that, to the best of his/her ability, the caseworker is available to assist the household in gathering information.

(2) All applicants shall be provided with the following information:

(a) ISD’s nondiscrimination policy and procedures;

(b) complaint and fair hearing procedures and clients’ rights;

(c) program procedures, including the use of IEVS, SDX, BENDEX information, and CSED and MVD interfaces;

(d) application processing standards, including time limits;

(e) procedures in cases of overissuance or under-issuance;

(f) regular reporting household's responsibility to report changes within ten days of the date the change becomes known to the household;

(g) semiannual reporting requirements for those household assigned to semiannual reporting including the:

(i) requirement to submit a semiannual report in the sixth month of the food stamp certification period;

(ii) requirement to report by the tenth day of the month following the month the household income exceeds 130% of federal poverty guidelines for the size of the household; and

(iii) option to report a change between reporting periods if the household thinks that it will result in an increase in food stamp benefits.

(h) requirement for cooperation with quality control reviewers (QC), including penalties for non-cooperation;

(i) work requirements and penalties for non-cooperation, including voluntary quit and associated penalties;

(j) responsibility to contact the local ISD office to reschedule missed appointments; and

(k) exemption from gross receipts tax collection by the retailer on eligible food purchased with food stamp benefits.

(3) Fair hearing information:

(a) Notification of right to request hearing: At the time of application each household shall be informed in writing of its right to a hearing, of the method by which a hearing may be requested, and that its case may be presented by a household member or representative, such as a legal counsel, relative, friend or other individual.

(b) Periodic notification: At any time a household informs the local office that it disagrees with an HSD action, the household shall be reminded of the right to request a fair hearing.

(c) Forwarding hearing request: A request for a hearing made either orally or in writing by a household or representative shall be forwarded to the fair hearings bureau. If it is unclear from a request what action a household or representative wishes to appeal, a clarification may be requested by HSD. The freedom to make a request for a hearing shall not be limited or interfered with in any way.

(d) Providing a hearing: The fair hearing process shall be available to any household which feels an action taken by HSD is incorrect, and which affects participation of the household in the food stamp program.

(e) Other representation: If there is an individual or organization available that provides free legal representation, the household shall be informed of the availability of that source.

(4) Agency conference information: A household shall be informed of the availability of an agency conference to resolve a dispute. HSD shall schedule an agency conference for a household when a dispute arises.

(a) Denial of expedited service: An agency conference shall be offered to a household which wishes to contest a denial of expedited service. An agency conference for such a household shall be scheduled within two (2) working days, unless the household requests that it be scheduled later or states that it does not wish to have an agency conference.

(b) Adverse actions: HSD may also offer an agency conference to a household adversely affected by an HSD action.

(c) Use of agency conference: HSD shall inform a household that use of an agency conference is optional and that it shall in no way delay or replace the fair hearing process.

G. Scheduling interviews: The interview on an initial application shall be scheduled within ten (10) working days, and, to the extent possible, at a time that is most convenient for the applicant.

H. Missed interviews: HSD shall notify a household that it missed its first interview appointment and that the household is responsible for rescheduling a missed interview. If the household contacts the caseworker within the 30-day application-processing period, the caseworker shall schedule a second interview. When the applicant contacts the local ISD office, either orally or in writing, the caseworker shall reschedule the interview as soon thereafter as possible within the 30-day processing period, without requiring the applicant to provide good cause for failing to appear. If the applicant does not contact the office or does not appear for the rescheduled interview, the application shall be denied on the 30th day (or the next work day) after the application was filed (see Section 8.139.110.12 NMAC).

I. Verification standards: Verification is use of third-party information or documentation to establish the accuracy of statements on the application, or information provided by the applicant or recipient.

(1) Initial certification: Verification is mandatory for the following information prior to initial certification for both new and reopened cases.

(a) Financial information:

(i) gross nonexempt income, and

(ii) resources.

(b) Any of the following if the expense would result in a deduction:

(i) utility expenses;

(ii) continuing shelter expenses;

(iii) dependent care expenses;

(iv) deductible medical expenses including the amount of reimbursements;

(v) legally obligated child support expenses, and amount actually paid.

(vi) If any of the above expenses will not result in a deduction, verification shall not be required (for example, less than $35 in medical expenses, or shelter expenses that do not exceed 50% of income after all other deductions).

(c) Nonfinancial information:

(i) residence,

(ii) citizenship, if questionable, and alien status of household members only;

(iii) identity of the applicant and authorized representative, if designated;

(iv) household size and composition;

(v) disability, if necessary;

(vi) social security numbers, except that eligibility or issuance of benefits shall not be delayed solely to verify the social security number of a household member, and

(vii) any questionable information that must be verified to determine eligibility.

(2) Recertification: Verification of the following is mandatory at recertification or for cases reopened within 30 days of expiration:

(a) a change in income if the source has changed or the amount has changed by more than $50.00.

(b) a change in utility expenses if the source has changed.

(c) previously unreported medical expenses, and total recurring medical expenses which have changed by more than $25.00.

(d) new social security numbers shall be verified as detailed in 8.139.410.8 NMAC.

(e) any other information which has changed or is questionable.

(f) unchanged information shall not be reverified unless it is incomplete, inaccurate, inconsistent, or outdated.

(3) Semiannual reporting: Verification standards for those households

assigned to semiannual reporting are set forth at 8.139.120.9 NMAC.

(4) Providing verification:

(a) The household has primary responsibility for providing documentary evidence to support statements on the application and to resolve any questionable information.

(b) The caseworker shall assist a household in obtaining verification, provided the household is cooperating in the application process.

(c) A household may supply documentary evidence in person, through the mail or through an authorized representative.

(d) A household shall not be required to supply verification in person at the food stamp office or to schedule an appointment to provide such verification.

(e) The caseworker shall accept any reasonable documentary evidence provided by the household and must be primarily concerned with how adequately the verification proves the statements on the application.

(5) Designating a collateral contact:

(a) Whenever evidence is insufficient to make a firm determination of eligibility or benefit amount, or cannot be obtained, the caseworker may require a collateral contact or a home visit.

(b) The caseworker shall rely on the household to provide the name of a collateral contact.

(c) A household may request assistance in designating a collateral contact.

(d) The caseworker shall not be required to use a collateral contact designated by the household if the collateral contact cannot be expected to provide accurate third-party verification.

(e) When a collateral contact designated by the household is unacceptable, the caseworker shall either designate another collateral contact, ask the household to designate another collateral contact, or provide another alternative form of verification such as a home visit.

(f) The caseworker is responsible for obtaining verification from acceptable collateral contacts.

(6) Documentation: A case file shall be documented to support eligibility, ineligibility, and benefit amount determination. Documentation shall be in sufficient detail to permit a reviewer to determine the reasonableness and accuracy of the determination.

[02/01/95, 06/01/95, 10/01/95, 06/01/99; 8.139.110.11 NMAC - Rn, 8 NMAC 3.FSP.113, 05/01/2001; A, 02/14/2002; A, 01/01/2004; A, 08/01/2008]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG TERM SERVICES
PART 1 GENERAL PROVISIONS

8.307.1.1 ISSUING AGENCY: Human Services Department
[8.307.1.1 NMAC - N, 8-1-08]

8.307.1.2 SCOPE: This rule applies to the general public.
[8.307.1.2 NMAC - N, 8-1-08]

8.307.1.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.307.1.3 NMAC - N, 8-1-08]

8.307.1.4 DURATION: Permanent
[8.307.1.4 NMAC - N, 8-1-08]

8.307.1.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.1.5 NMAC - N, 8-1-08]

8.307.1.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.1.6 NMAC - N, 8-1-08]

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

A. Definitions beginning with letter "A":

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

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

(3) **Activities of daily living:** Activities necessary for daily living, including eating, dressing, oral hygiene, bathing, mobility, toileting, grooming, taking medications, transferring from a bed or chair, and walking, consistent with NMSA 1978 Section 28-17-3

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

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

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

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

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

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

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

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

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

B. Definitions beginning with letter "B":

(1) **Begin date:** The first day of the first full month following selection of or assignment to a CLTS MCO/SE. For members who are in a nursing facility prior to the level of care determination but not enrolled in medicaid or medicare managed care, the begin date will be the first of the month in which both nursing facility level of care and medicaid eligibility exists.

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

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

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

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

C. Definitions beginning with letter "C":

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

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

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

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

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

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

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

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

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

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

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

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

(13) **Concurrent review:** A process of updating clinical information from a service provider to a CLTS MCO/SE regarding a member who is already receiving a covered service, to evaluate whether the service continues to be medically necessary.

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

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

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

(17) **Coordinated long-term services:** A coordinated program of physical health and community-based supports and services implemented under the authority of concurrent section 1915(b) and section 1915(c) waivers.

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

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

(20) **Cultural competence:** A set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals, that enables them to work effectively in cross-cultural situations. Cultural competency involves the integration and transformation of knowl-

edge, information and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques, and marketing programs that match an individual's culture to increase the quality and appropriateness of health care and outcomes.

D. Definitions beginning with letter "D":

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

(2) **Denial, administrative/technical:** A denial of authorization requests due to the requested procedure, service or item not being covered by medicaid, not being on the CLTS MCO/SE formulary or due to provider noncompliance with administrative policies and procedures established by either the CLTS MCO/SE or the medical assistance division.

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

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

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

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

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

E. Definitions beginning with letter "E":

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

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

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

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

(5) **Enrollee rights**: Rights that each coordinated long-term services enrollee is guaranteed.

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

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

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

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

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

F. Definitions beginning with letter "F":

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

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

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

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

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

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

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

G. Definitions beginning with letter "G":

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

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

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

H. Definitions beginning with letter "H":

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

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

(3) **Hearing or fair hearing:** An administrative hearing that is held so that evidence may be presented. (See 8.352.2 NMAC, R*ecipient Hearings*.)

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

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

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

I. Definitions beginning with letter "I":

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

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

(3) **Individuals with special health care needs (ISHCN):** Individuals who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition, or have low to severe functional limitation and who also require health and related services of a type or amount beyond that required by individuals generally.

J - K. [RESERVED]

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

M. Definitions beginning with letter "M":

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

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

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

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

(5) **Medically necessary services:**

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

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

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

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

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

(b) Application of the definition:

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

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

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

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

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

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

N. Definitions beginning with letter "N":

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

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

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

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

O. [RESERVED]

P. Definitions beginning with letter "P":

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) a physician assistant;

(b) a nurse practitioner; or

(c) a certified nurse midwife.

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

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

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

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

R. Definitions beginning with letter "R":

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

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

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

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

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

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

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

S. Definitions beginning with letter "S":

(1) **Service coordination:** A specialized service management that is performed by a service coordinator, in collaboration with the member or the member's family or representatives as appropriate, that is person-centered, and that includes, but is not limited to: (a) identification of the member's needs, including physical health services, mental health services, social services, and long-term support services; and development of the member's ISP or treatment plan to address those needs; (b) assistance to ensure timely and coordinated access to an array of providers and services; (c) attention to addressing unique needs of members; and (d) coordination with other services delivered outside the ISP, as necessary and appropriate. Service coordination operates independently within the CLTS MCO/SE using recognized professional

standards adopted by the CLTS MCO/SE and approved by the state, based on the service coordinator's independent judgment to support the needs of the member and is structurally linked to the other CLTS MCO/SE systems, such as quality assurance, member services and grievances. Clinical and other decisions shall be based on medical necessity and not on fiscal considerations.

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

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

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

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

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

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

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

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

T. Definitions beginning with letter "T":

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

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

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

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

U. Definitions beginning with letter "U":

(1) **Urgent condition:** Acute signs and symptoms that, by reasonable medical judgment, represent a condition of sufficient severity such that the absence of medical attention within 24 hours could reasonably be expected to result in an emergency condition.

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

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

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

X - Z. [RESERVED]

[8.307.1.7 NMAC - N, 8-1-08]

8.307.1.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.

[8.307.1.8 NMAC - N, 8-1-08]

HISTORY OF 8.307.1 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG TERM SERVICES
PART 2 MEMBER EDUCATION

8.307.2.1 ISSUING AGENCY: Human Services Department

[8.307.2.1 NMAC - N, 8-1-08]

8.307.2.2 SCOPE: This rule applies to the general public.

[8.307.2.2 NMAC - N, 8-1-08]

8.307.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.

[8.307.2.3 NMAC - N, 8-1-08]

8.307.2.4 DURATION: Permanent

[8.307.2.4 NMAC - N, 8-1-08]

8.307.2.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.

[8.307.2.5 NMAC - N, 8-1-08]

8.307.2.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.

[8.307.2.6 NMAC - N, 8-1-08]

8.307.2.7 DEFINITIONS: See 8.307.1.7 NMAC.

[8.307.2.7 NMAC - N, 8-1-08]

8.307.2.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.

[8.307.2.8 NMAC - N, 8-1-08]

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

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

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

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

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

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

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

(6) to ensure through its network providers that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) information regarding language accessibility;

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

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

(g) description of mandatory benefits;

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

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

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

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

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

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

(n) information regarding advance health directives;

(o) information regarding obtaining a second opinion;

(p) information on cost sharing, if any;

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

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

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

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

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

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

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

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

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

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

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

(f) description of mandatory benefits;

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

(h) limitations to the receipt of care from out-of-network providers; a list of services for which prior authorization or a referral is required and the method of obtaining both;

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

(k) information regarding advance directives;

(l) information regarding obtaining a second opinion;

(m) information on cost sharing, if any; and

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

(3) The provider directory must include the following:

(a) CLTS MCO/SE addresses and telephone numbers;

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

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

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

E. **Other requirements:**

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

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

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

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

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

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

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

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

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

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

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

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

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

return the telephone call by the next business day.

I. **Member services meetings:** The CLTS MCO/SE shall meet as requested with HSD or its designee's staff for member services meetings. Member services meetings are held to plan outreach and medicaid enrollment activities and events that will be jointly conducted by the CLTS MCO/SE and HSD or its designee's outreach staff.
[8.307.2.9 NMAC -N, 8-1-08]

HISTORY OF 8.307.2 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG TERM SERVICES
PART 3 CONTRACT MANAGEMENT

8.307.3.1 ISSUING AGENCY: Human Services Department
[8.307.3.1 NMAC - N, 8-1-08]

8.307.3.2 SCOPE: This rule applies to the general public.
[8.307.3.2 NMAC - N, 8-1-08]

8.307.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.307.3.3 NMAC - N, 8-1-08]

8.307.3.4 DURATION: Permanent
[8.307.3.4 NMAC - N, 8-1-08]

8.307.3.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.3.5 NMAC - N, 8-1-08]

8.307.3.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.3.6 NMAC - N, 8-1-08]

8.307.3.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.3.7 NMAC - N, 8-1-08]

8.307.3.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.3.8 NMAC - N, 8-1-08]

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

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

B. **Contract issuance:** The risk-based contracts shall be awarded for at least a two-year period. Contracts are issued to offerors meeting requirements specified under the terms of the coordinated long-term services contract.
[8.307.3.9 NMAC - N, 8-1-08]

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

A. **General contract requirements:** The CLTS MCO/SE shall meet all specified terms of the medicaid contract with HSD as it relates to medicaid members and services and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This includes, but is not limited to, ensuring confidentiality as it relates to medical records and any other health and enrollment information that identifies a particular member. The CLTS MCO/SE shall be held harmless in conversion to HIPAA electronic transmission formats when delays are the result of implementation issues at HSD.

B. **Subcontracting requirements:** The CLTS MCO/SE may subcontract to a qualified individual or organization the provision of services defined in the benefit package or other required CLTS MCO/SE functions. The CLTS MCO may not assign, transfer or delegate key management functions such as utilization review, utilization management, or service coordination without the explicit written approval of the state. The CLTS MCO/SE shall submit boilerplate contract language and sample contracts for various types of subcontracts. Any substantive changes to contract templates shall be approved by HSD prior to issuance. The CLTS MCO must oversee and be held accountable for any function or responsibility, including claims submission requirements, that it delegates to any subcontractor. The CLTS MCO shall have policies and procedures to ensure that the subcontractor meets all standards of performance mandated by the state for the coordinated long-term services program, including the use of appropriately qualified staff, application of clinical practice guidelines and utilization management, reporting capability, and ensuring access to services for members. The SE may assign, transfer, or delegate to a subcontractor key management functions including, but not limited to, care coordination and universal credentialing with the explicit written approval of HSD and the collaborative.

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

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

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

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

(b) subcontracts shall identify the parties of the subcontract and the parties' legal basis to operate in the state of New Mexico;

(c) subcontracts shall include procedures and criteria for terminating the subcontract;

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

(e) subcontracts must describe how members access services provided

under the subcontract;

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

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

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

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

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

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

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

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

(n) subcontracts shall have a provision for terminating, rescinding, or canceling the contracts for violation of applicable HSD requirements;

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

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

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

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

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

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

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

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

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

C. **Provider incentive plans:** The CLTS MCO/SE shall ensure that direct or indirect incentives offered in the subcontract shall not serve as an inducement to reduce or limit medically necessary services to members.
[8.307.3.10 NMAC - N, 8-1-08]

8.307.3.11 ORGANIZATIONAL REQUIREMENTS:

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

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

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

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

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

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

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

(3) **Business requirements:** The CLTS MCO/SE shall have the administrative, information and other systems in place necessary to fulfill the terms of the medicaid coordinated long-term services and behavioral health contracts. Any change in identified key CLTS MCO/SE personnel shall conform to the requirements of the coordinated long-term services and behavioral health contracts. The CLTS MCO/SE shall retain financial records, supporting documents, statistical records, and all other records for a period of 10 years from the date of submission of the final expenditure report, except as specified by HSD or its designee.

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

(5) **Member services:** The CLTS MCO/SE shall have a member services function that coordinates communication with members and acts as a member advocate. Member services shall include sufficient staff to assist members in resolving problems or making inquiries. The CLTS MCO's/SE's policies and procedures shall be made available upon request to members

or member representatives for review during normal business hours.

(6) **Consumer advisory board:** The CLTS MCO/SE shall establish their respective consumer advisory board that includes regional representation of consumers, family members, advocates and service providers. The SE's behavioral health consumer advisory board shall also interact with the behavioral health planning council (BHPC) as directed by the collaborative. The CLTS MCO and the SE consumer advisory boards shall interface and collaborate with one another as appropriate. The CLTS MCO consumer advisory board shall consist of an equitable representation of the CLTS MCO's members in terms of race, gender, special populations and geographic areas of the state.

(a) The consumer advisory board members shall serve to advise the CLTS MCO and the SE respectively on issues concerning service delivery and quality of service; the member bill of rights and member responsibilities; resolution of member grievances; and the needs of groups represented by board members as they pertain to medicaid, including coordinated long-term services. The consumer advisory boards shall meet at least quarterly and keep a written record of meetings. The CLTS MCO consumer advisory board shall keep a written record of all attempts to invite and include its members in its meetings. The board roster and minutes shall be made available to HSD or its designee upon request. The CLTS MCO/SE shall advise HSD or its designee 10 days in advance of meetings to be held. HSD or its designee shall attend and observe consumer advisory board meetings at its discretion.

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

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

(a) require plans of correction;

(b) impose directed plans of correction; and

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

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

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

(iii) penalty assessments shall range up to five percent of the CLTS MCO's/SE's medicaid capitation payment for the month in which the penalty is assessed;

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

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

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

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

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

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

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

(e) adjust automatic assignment formula;

(f) rescind marketing consent;

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

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

(i) deny payment;

(j) assess actual damages;

(k) assess liquidated damages;

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

(m) allow members to terminate enrollment;

(n) suspend agreement;

(o) terminate the CLTS MCO/SE contract;

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

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

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

(ii) there is substantial risk to the health and safety of the CLTS MCO's/SE's members; or

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

C. HSD shall not delay the imposition of temporary management to provide a hearing before imposing this sanction. HSD shall not terminate temporary management until it determines that the CLTS MCO/SE can ensure that the sanctioned behavior will not reoccur. Refer to state and federal regulations for due process procedures.

[8.307.3.11 NMAC - N, 8-1-08]

HISTORY OF 8.307.3 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG TERM SERVICES
PART 4 ELIGIBILITY

8.307.4.1 ISSUING AGENCY: Human Services Department
[8.307.4.1 NMAC - N, 8-1-08]

8.307.4.2 SCOPE: This rule applies to the general public.
[8.307.4.2 NMAC - N, 8-1-08]

8.307.4.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See

NMSA 1978 Section 27-2-12 et. seq.
[8.307.4.3 NMAC - N, 8-1-08]

8.307.4.4 DURATION: Permanent
[8.307.4.4 NMAC - N, 8-1-08]

8.307.4.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.4.5 NMAC - N, 8-1-08]

8.307.4.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.4.6 NMAC - N, 8-1-08]

8.307.4.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.4.7 NMAC - N, 8-1-08]

8.307.4.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.4.8 NMAC - N, 8-1-08]

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

A. **Included populations:** Populations included in the coordinated long-term services program are:

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

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

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

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

(5) individuals in the mi via 1915 (c) waiver who meet current disabled and elderly or brain injury categories of eligibility; the CLTS MCO/SE will only be at risk and financially responsible for the 1915 (b) waiver services for these individuals; the individuals will self-direct any 1915 (c) waiver services.

B. **Excluded populations:** Populations excluded from the coordinated long-term services program are:

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

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

(3) consumers participating in SALUD!;

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

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

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

C. The state, or its designee, shall further determine eligibility for CLTS 1915 (c) home and community-based waiver services through an allocation process.
[8.307.4.9 NMAC - N, 8-1-08]

8.307.4.10 SPECIAL SITUATIONS:

A. **Hospitalized members:** If a CLTS member is hospitalized at the time of disenrollment from the coordinated long-term services program or an approved switch to another CLTS MCO, the CLTS MCO shall be responsible until the date of discharge for payment for all covered facility and professional services provided within a licensed acute care facility or non-psychiatric specialty unit as designated by the New Mexico department of health. The payer at the date of hospital admission (coordinated long-term services or medicaid fee-for-service) remains responsible for services until the date of discharge. Services provided at a free-standing psychiatric hospital or within a psychiatric unit of an acute care hospital are the responsibility of the SE. Upon discharge, the member will then become the financial responsibility of the organization or entity receiving capitation payments. Transition services (e.g., durable medical equipment supplies for the home) shall be the financial responsibility of the CLTS MCO. The originating and receiving organization are both required to ensure continuity and coordination of services during the transition.

B. **Members receiving hospice services:** Members who have elected and are receiving hospice services prior to enrollment in the coordinated long-term services program are exempt from enrolling in a CLTS MCO unless they revoke their hospice election.

C. **Members in third trimester of pregnancy:** A woman in her third trimester of pregnancy at the time of enrollment, who has an established obstetrical provider may continue that relationship. Refer to Paragraph (4) of Subsection H of 8.307.11.9 NMAC for special payment requirements.

D. **Members placed in institutional care facilities for the mentally retarded (ICF/MR):** If a member is placed in an ICF/MR for what is expected to be a long-term or permanent placement, the CLTS MCO/SE remains responsible for the member until the member is disenrolled by HSD.
[8.307.4.10 NMAC - N, 8-1-08]

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

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

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

HISTORY OF 8.307.4 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG TERM SERVICES
PART 5 ENROLLMENT

8.307.5.1 ISSUING AGENCY: Human Services Department
[8.307.5.1 NMAC - N, 8-1-08]

8.307.5.2 SCOPE: This rule applies to the general public.
[8.307.5.2 NMAC - N, 8-1-08]

8.307.5.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to

regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.307.5.3 NMAC - N, 8-1-08]

8.307.5.4 DURATION: Permanent
[8.307.5.4 NMAC - N, 8-1-08]

8.307.5.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.5.5 NMAC - N, 8-1-08]

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

8.307.5.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.5.7 NMAC - N, 8-1-08]

8.307.5.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.5.8 NMAC - N, 8-1-08]

8.307.5.9 ENROLLMENT PROCESS:

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

B. **Selection period:** The member shall have at least 16 calendar days to select a CLTS MCO upon notification by the state, or its designee, that eligibility for CLTS has been established. If a selection is not made in 16 days, the member shall be assigned to a CLTS MCO by the human services department (HSD) or its designee. Members mandated into managed care shall be automatically assigned to the SE.

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

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

(2) **Enrollment based on case (family) continuity:** Enrollment based on case continuity is applied in the following manner: **Processing case continuity:** The member is enrolled with the CLTS MCO to which a majority of the case (family) members is assigned, if applicable. If an equal number of case (family) members are assigned to different CLTS MCOs and a majority cannot be identified, the member is assigned to a CLTS MCO to which other case (family) members are assigned.

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

D. **Begin date of enrollment:** Enrollment begins the first day of the first full month following selection or assignment, except if the member entered a nursing facility while enrolled with the medicaid fee-for-service program and both the member's nursing facility level of care and medicaid eligibility precede the first full month following selection. Retroactive eligibility is limited to a maximum of six months.

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

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

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

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

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

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

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

(6) Member disenrollment from CLTS may occur to enroll in PACE.

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

(1) continuity of service issues;

(2) family continuity;

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

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

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

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

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

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

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

I. **Disenrollment, CLTS MCO/SE initiated:** The CLTS MCO/SE may request that a particular member be disenrolled from the coordinated long-term services program. Member disenrollment from a CLTS MCO/SE shall be considered in rare circumstances. Disenrollment requests shall be made in writing to HSD. The request and supporting documentation shall meet HSD conditions stated below in Subsection I of 8.307.5.9 NMAC, *enrollment process*. The CLTS MCO/SE shall not request disenrollment because of an adverse change in the member's health status or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the member's special needs, except when the member's continued enrollment with the CLTS MCO/SE seriously impairs the CLTS MCO's/SE's ability to furnish services to either this particular member or other members. The CLTS MCO/SE shall notify the member in writing of the disenrollment request at the same time the request is submitted to HSD. The CLTS MCO/SE shall submit a copy of the member's notification letter to HSD. If the disenrollment is granted, the CLTS MCO/SE retains responsibility for the member's services until the member is enrolled with another CLTS MCO or exempted from the coordinated long-term services program. In the case of the SE, the member would be exempt from the SE medicaid managed care and would receive behavioral health benefits under the medicaid fee-for-service (FFS) program. The CLTS MCO/SE shall assist with transition of care.

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

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

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

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

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

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

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

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

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

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

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

[8.307.5.9 NMAC - N, 8-1-08]

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

[8.307.5.10 NMAC - N, 8-1-08]

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

[8.307.5.11 NMAC - N, 8-1-08]

8.307.5.12 MASS TRANSFER

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

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

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

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

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

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

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

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

[8.307.5.12 NMAC - N, 8-1-08]

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

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

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

(2) all marketing and outreach materials produced by the CLTS MCOs/SE under the medicaid coordinated long-term services and behavioral health contracts shall state that such services are funded in part under contract with the state of New Mexico;

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

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

(5) other requirements specified by the state.

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

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

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

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

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

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

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

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

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

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

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

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

(4) making inaccurate, misleading or exaggerated statements;

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

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

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

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

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

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

(11) seeking to influence enroll-

ment in conjunction with the sale or offering of any private insurance; and

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

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

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

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

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

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

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

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

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

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

[8.307.5.13 NMAC - N, 8-1-08]

HISTORY OF 8.307.5 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG TERM SERVICES
PART 6 PROVIDER NETWORKS

8.307.6.1 ISSUING AGENCY: Human Services Department
[8.307.6.1 NMAC - N, 8-1-08]

8.307.6.2 SCOPE: This rule applies to the general public.
[8.307.6.2 NMAC - N, 8-1-08]

8.307.6.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.307.6.3 NMAC - N, 8-1-08]

8.307.6.4 DURATION: Permanent
[8.307.6.4 NMAC - N, 8-1-08]

8.307.6.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.6.5 NMAC - N, 8-1-08]

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

8.307.6.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.6.7 NMAC - N, 8-1-08]

8.307.6.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.6.8 NMAC - N, 8-1-08]

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

A. **Service coverage:** The CLTS MCO/SE shall provide or arrange for the provision of services described in 8.307.7 NMAC, *Benefit Package*, in a timely manner. The CLTS MCO/SE is solely responsible for the provision of covered services and must ensure that its network includes providers in sufficient numbers and required specialists to make all services included in the package available and in accordance with access standards.

B. **Comprehensive network:** The CLTS MCO/SE shall contract with the full array of providers necessary to deliver a level of service at least equal to, or better than, community norms. The CLTS MCO shall contract with a number of providers sufficient to maintain equivalent or better access than that available under medicaid fee-for-service (FFS). The CLTS MCO shall have at least a single case agreement with all current medicaid nursing facility, disabled and elderly (D&E) waiver, and personal care option (PCO) providers as either out-of-network or contracted providers for at least the minimum 60 days during which the prior authorization for these services is being honored. Unless otherwise provided for, the CLTS MCO shall pay at least the HSD/MAD fee-for-service rates for services provided to members if the CLTS MCO is unable to reach a negotiated rate with a provider. The CLTS

MCO/SE shall take into consideration the characteristics and health/long-term service needs of its individual medicaid populations. The CLTS MCO/SE must contractually require that all network providers and subcontractors be in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In establishing and maintaining the network of appropriate providers, the CLTS MCO/SE shall consider the following:

(1) the numbers of network providers who are not accepting new medicaid members;

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

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

C. **Maintenance of provider network:** The CLTS MCO/SE shall notify the human services department (HSD) or its designee within five working days of unexpected changes to the composition of its provider network that negatively affect members' access or the CLTS MCO's/SE's ability to deliver services included in the benefit package in a timely manner. Anticipated material changes in a CLTS MCO/SE provider network shall be reported to HSD or its designee in writing within 30 days prior to the change, or as soon as the CLTS MCO/SE knows of the anticipated change. A notice of material change must contain:

(1) the nature of the change;

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

(3) the CLTS MCO/SE's plan for maintaining access and the quality of member services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[8.307.6.9 NMAC - N, 8-1-08]

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

A. **Individual professional service providers:** For individual professional service providers, the CLTS MCO shall:

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

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

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

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

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

B. **Organizational providers:** For organizational providers, the CLTS MCO shall:

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

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

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

(4) develop and implement standards of participation that demonstrate that the service provider is in compliance with provider participation requirements under applicable federal law and regulations, if

the service provider has not been approved by an accrediting body.

C. **Primary source verification:**

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

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

[8.307.6.10 NMAC - N, 8-1-08]

8.307.6.11 UTILIZATION OF OUT-OF-STATE PROVIDERS: To the extent possible, the CLTS MCO/SE is encouraged to utilize in-state and border service providers, which are defined as those service providers located within 100 miles of the New Mexico border, Mexico excluded. The CLTS MCO/SE may include out-of-state service providers in its network.

[8.307.6.11 NMAC - N, 8-1-08]

8.307.6.12 PRIMARY CARE PROVIDERS: The PCP must be a participating CLTS MCO medical provider that has the responsibility for supervising, coordinating and providing primary health services to members, initiating referrals for specialist services and maintaining the continuity of the member's services. The CLTS MCO shall have a formal process for provider education regarding Medicaid, the conditions of participation in the network and the provider's responsibilities to the CLTS MCO and its members. The training shall also include the identification of special populations and their service needs.

A. **Primary care for dual eligibles:** These PCP regulations apply to all coordinated long-term services program recipients except members who are dually eligible for medicare and medicaid (dual eligibles), and whose primary and acute physical health services are covered by medicare. For dual eligible members, the CLTS MCO is responsible for coordinating the member's primary, acute and long-term care services with the medicare PCP.

B. **Primary care for Native Americans:** The CLTS MCO shall develop policies and procedures to ensure that services are coordinated with the Indian Health Service (IHS), tribal 638 programs and facilities, and other tribal entities as appropriate.

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

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

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

(3) maintenance of a current medical record for the member, including documentation of services provided to the member by the PCP and specialty or referral services not in contract;

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

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

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

(7) ensuring that services are coordinated with other types of health and social program providers and that PCPs are identifying and referring members to specialty providers as medically necessary;

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

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

(10) requiring PCPs to comply with timely access to care requirements, monitor regularly to determine this compliance and take corrective action if there is failure to comply.

D. **Types of PCPs:** The CLTS MCO may designate the following providers as PCPs, as appropriate:

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

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

(3) specialists, on an individualized basis, for members whose services are more appropriately managed by a specialist, such as members with infectious diseases, chronic illnesses or disabilities;

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

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

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

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

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

(a) The CLTS MCO shall assume responsibility for assisting members with PCP selection.

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

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

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

(iii) a member shall choose a PCP within five business days of enrollment with the CLTS MCO; a member may select a PCP from the information provided by the CLTS MCO; a member may choose a PCP anytime during this selection period;

(iv) the CLTS MCO shall make auto-assignments no later than five business days from enrollment for any member who has not selected a PCP in that timeframe. The CLTS MCO shall assign a PCP based on factors such as the member's age, residence and, if known, current provider relationship;

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

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

(2) **Subsequent change in PCP initiated by member:** Members may initiate a PCP change at any time, for any reason. The request for PCP change may be made in writing or by telephone. If the change is requested by the 20th day of the month, it will become effective on the first day of the following month. If the request is made after the 20th day of the month, it will become effective no later than the first day of the second month following the request. A PCP change may also be initiated on behalf of a member by the member's parent(s) or legal guardian(s) of a minor or incapacitated adult.

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

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

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

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

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

(e) a member's PCP is suspended for potential quality or fraud and abuse issues.

(4) **PCP lock-in:** HSD shall allow the CLTS MCO to require that a member see a certain provider while ensuring reasonable access to quality services when utilized services have been identified as unnecessary, when a member's behavior is detrimental, or when a need is indicated to provide case continuity. Prior to placing a member on PCP lock-in, the CLTS MCO shall inform the member of the intent to lock-in, including the reasons for imposing the PCP lock-in and notice that the restriction does not apply to emergency services furnished to the member. The CLTS MCO's grievance procedure shall be made available to a member disagreeing with the PCP lock-in. The PCP lock-in shall be reviewed and documented by the CLTS MCO and reported to the state every quarter. The member shall be removed from PCP lock-in when the CLTS MCO has determined that the utilization problems or detrimental behavior have ceased and that recurrence of the problems is judged to be improbable. The state shall be notified of all lock-in removals at the time they occur.

(5) **Pharmacy lock-in:** HSD shall allow the CLTS MCO to require that a member see a certain pharmacy provider for whom compliance or drug seeking behavior is suspected. Prior to placing the member on pharmacy lock-in, the CLTS MCO shall inform the member and the member's representative(s) of the intent to lock-in. The pharmacy lock-in shall be reviewed and documented by the CLTS MCO and reported to the state every quarter. The member shall be removed from pharmacy lock-in when the CLTS MCO has determined that the compliance issue or drug seeking behavior has been resolved and that the recurrence of the problems is judged to be improbable. The state shall be notified of all lock-in removals at the time they occur.

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

[8.307.6.12 NMAC - N, 8-1-08]

8.307.6.13 LONG-TERM SERVICES PROVIDERS: The CLTS MCO shall contract with medical providers, home and community based providers, and institutional providers that have the responsibility for supervising, coordinating and providing long-term services to members.

A. The CLTS MCO is prohibited from excluding long-term services providers based on the proportion of high-risk members in their caseloads.

B. The CLTS MCO shall have a formal process for provider education regarding the coordinated long-term services program, the conditions of participation in the program, and the provider's responsibilities to the CLTS MCO and its members. The state shall be provided with documentation, upon request, that such provider education is being conducted.

C. The CLTS MCO shall retain responsibility for monitoring long-term services provider activities to ensure compliance with the CLTS MCO's policies, and state and federal policies and regulations. The CLTS MCO shall educate long-term services providers about special populations and their service needs. The CLTS MCO shall ensure that long-term services providers successfully identify and refer members to PCPs for referral to specialty providers as medically necessary.

[8.307.6.13 NMAC - N, 8-1-08]

8.307.6.14 SPECIALTY PROVIDERS:

A. The CLTS MCO/SE shall contract with a sufficient number of specialists with the applicable range of expertise to ensure that the anticipated needs of its members will be met within the CLTS MCO/SE network of service providers. The CLTS MCO/SE shall have a system in place to refer members to service providers who are not affiliated with the CLTS MCO/SE network if providers with the necessary qualifications or certifications to provide the required services do not participate in the CLTS MCO's/SE's network.

B. The CLTS MCO/SE shall have written policies and procedures for coordination of services and the arrangement and documentation of all referrals. The CLTS MCO/SE policies and procedures shall designate the process used by the CLTS MCO/SE to ensure that referrals for all medically necessary services are available to members. The CLTS MCO/SE referral process shall be effective and efficient and not impede timely access to and receipt of services.

C. A woman in her third trimester of pregnancy at the time of enrollment, who has an established obstetrical provider, may maintain that relationship. (Refer to Paragraph (4) of Subsection H of 8.307.11.9 NMAC, *reimbursement for women in the third trimester of pregnancy*.)

D. The CLTS MCO/SE or a specialist may initiate a change of specialists when the member's/guardian's behavior toward the specialist is such that all reasonable efforts have been made to accommodate the member /guardian and address the member's problems, but those efforts have been unsuccessful.

[8.307.6.14 NMAC - N, 8-1-08]

8.307.6.15 ACCESS TO SERVICES: The CLTS MCO/SE shall demonstrate that its network is sufficient to meet the health service needs of enrolled members. HSD or its designee shall assess the sufficiency of this network throughout the contract period. The CLTS MCO/SE shall notify HSD or its designee of changes in its network as required. Changes affecting member access to services shall be communicated to HSD or its designee and remedied by the CLTS MCO/SE in an expeditious manner.

A. **Provider to member**

ratios:

(1) **PCP to member ratios:** The CLTS MCO shall ensure that the member caseload of any PCP in its network does not exceed 1,500 of its own members. Exceptions to this limit may be made with the consent of the CLTS MCO and HSD or its designee. Reasons for exceeding the limit may include continuation of established services, assignment of a family unit or availability of mid-level clinicians in the practice that expand the capacity of the PCP.

(2) **Specialist to member ratios:** HSD shall not establish specific specialist to member ratios. The CLTS MCO/SE must ensure that its members have adequate access to specialty services.

B. **Compliance with specified access standards:** The CLTS MCO/SE shall comply with all access standards delineated under the terms of the medicaid coordinated long-term services contract with respect to geographic location and scheduling and wait times.

C. **Requirements for CLTS MCO/SE policies and procedures:** The CLTS MCO/SE shall maintain written policies and procedures describing how members and service providers receive instructions on accessing services, including prior authorization and referral requirements for various types of medical or surgical treatments, emergency room services, and behavioral health services. The policies and procedures shall be made available in an accessible format, upon request, to HSD or its designee, network providers and members.

[8.307.6.15 NMAC - N, 8-1-08]

8.307.6.16 OTHER PROVIDERS: The CLTS MCO/SE shall demonstrate how it incorporates and utilizes certain other service providers that serve many of the special needs of medicaid members and are considered important in maintaining continuity of services.

A. **Federally qualified health centers (FQHCs) and rural health centers:** The CLTS MCOs/SE shall contract with FQHCs and rural health centers to the extent that access is required by federal law and pursuant to state regulations.

B. **Public health providers:** The CLTS MCOs/SE shall contract with public health service providers, including local and district public health offices, pursuant to state law and regulations.

(1) **Specific requirements for local and district health offices:** The CLTS MCO must contract with local and district public health offices to provide the following services:

(a) family planning services;

(b) the CLTS MCO may require PCPs to participate in the vaccines for children (VFC) program administered by the department of health; and

(c) the CLTS MCO may contract with local and district health offices for other clinical preventive services not otherwise available in the community, such as prenatal services or perinatal case management.

(2) **Shared responsibility between CLTS MCO and public health offices:** The CLTS MCO shall coordinate with public health offices regarding the following services:

(a) screening, diagnosis, treatment, follow-up and contact investigations of sexually transmitted disease;

(b) HIV prevention counseling, testing and early intervention;

(c) screening, diagnosis and treatment of tuberculosis;

(d) disease outbreak prevention and management, including reporting according to state law requirements, responding to epidemiology requests for information and coordination with epidemiology investigations and studies;

(e) referral and coordination to ensure maximum participation in the supplemental food program for women, infants and children (WIC);

(f) health education services for individuals and families with a particular focus on injury prevention including, but not limited to, car seat use, domestic violence, substance use, and lifestyle issues including tobacco use, exercise and nutrition;

(g) development and support for family support programs, such as home visiting programs for families of newborns and other at-risk families and parenting education;

(h) participating in and support for local health councils to create healthier and safer communities with a focus on coordination of efforts such as DWI councils, maternal and child health councils, tobacco coalitions, safety councils, safe kids and others; and

(i) vaccines for children program.

C. **Children's medical services:** The CLTS MCO shall contract with children's medical services, which administers outreach clinics at sites throughout the state. The children's medical service clinics offer pediatric sub-specialty services in local communities, which include cleft palate, neurology, endocrine, asthma and pulmonary services.

D. **School-based providers:** The CLTS MCO/SE must make every effort to include school-based health clinics as network providers or provide the same level of access in the school setting.

E. **Assisted living facilities:** The CLTS MCO shall ensure that assisted living network providers meet the fundamental principles of practice for home and community-based services, as set forth in the coordinated long-term services contract.

F. The CLTS MCO shall contract with other service providers, as needed, to provide services identified in the member's individualized service plan (ISP).

G. **Indian health services (IHS) and tribal health centers:** The CLTS MCO/SE shall allow members who are Native American to seek services from IHS, tribal or urban Indian program service providers defined in the Indian Health Care Improvement Act (25 U.S.C. Sections 1601 et seq.), whether or not the service provider participates as part of the CLTS MCO's or SE's provider network. The CLTS MCO/SE may not prevent members who are IHS beneficiaries from seeking services from IHS, tribal or urban Indian service providers. The CLTS MCO/SE shall make good faith efforts to contract with service providers that include, but are not limited to, IHS, 638 tribal programs and service providers serving particular linguistic or cultural groups. The CLTS MCO/SE shall track IHS utilization and expenditures by Native American members. The CLTS MCO/SE shall not require prior authorization for services provided within the IHS and tribal 638 network. The CLTS MCO/SE shall accept an individual service provider employed by the IHS or tribal 638 facility who holds a current license to practice in the United States or its territories as meeting licensure requirements.

H. **State-run institutions.** The CLTS MCO/SE shall make every effort to use certain state-run institutions that provide highly specialized services and provide a "safety net" function for certain high-risk populations.

[8.307.6.16 NMAC - N, 8-1-08]

8.307.6.17 FAMILY PLANNING PROVIDERS: Federal law does not allow restricting access to family planning services for individuals enrolled in medicaid.

A. The CLTS MCO shall maintain written policies and procedures defining how members are educated about their right to family planning services, freedom of provider choice and method of accessing such services. The CLTS MCO shall ensure that its policies and procedures for accessing family planning services meet specified requirements for member communication.

B. The CLTS MCO shall give each member, including adolescents, the opportunity to use the member's PCP, or go to any family planning center, for family

planning services without requiring a referral. Each female member shall also have the right to self-refer to a women's health specialist within the CLTS MCO's network for covered services necessary to provide women's routine and preventive health care services. This right to self-refer is in addition to the member's designated source of primary care if that source is not a women's health specialist.

C. Clinics and service providers, including those funded by Title X of the Public Health Service Act, shall be reimbursed by the CLTS MCO, regardless of whether they are network or non-network providers. The CLTS MCO shall implement procedures to reimburse out-of-network family planning providers that serve its members.

D. Non-participating service providers are responsible for keeping family planning information confidential in favor of the individual patient, even if the patient is a minor.

[8.307.6.17 NMAC - N, 8-1-08]

8.307.6.18 PROVIDER EDUCATION AND COMMUNICATION:

A. The CLTS MCO/SE shall establish and maintain policies and procedures governing the development and distribution of education and informational materials regarding coordinated long-term services, including behavioral health, to its network providers. Policies and procedures shall:

(1) inform service providers of the conditions of participation with the CLTS MCO/SE;

(2) inform service providers of their responsibilities to the CLTS MCO/SE and to medicaid members;

(3) inform service providers of medicaid-specific policies and procedures, including information on primary and specialized medical services and related information and services specific to the needs of individuals with special health care needs (ISHCN) and other special populations;

(4) inform service providers regarding cultural competency and provide ongoing educational opportunities for providers and their staff on cultural competency;

(5) provide information on credentialing and recredentialing, prior authorization and referral processes and how to request and obtain a second opinion;

(6) inform service providers on how to access service coordination services for physical, behavioral and social support needs, including covered benefits and services outside the benefit package;

(7) inform service providers regarding the delivery of federally mandated EPSDT services; and

(8) furnish service providers with information on the CLTS MCO's/SE's internal provider grievance process by which providers can dispute a CLTS MCO/SE action or file a complaint.

B. In addition to the above, the CLTS MCO/SE shall:

(1) conduct an annual service provider satisfaction survey, the results of which will be incorporated into the CLTS MCO's/SE's quality improvement (QI) program; survey results will be forwarded to HSD or its designee;

(2) actively solicit input from its network providers in an effort to improve and resolve problem areas related to the coordinated long-term services program; the information provided will be incorporated into the CLTS MCO's or SE's QI program; and

(3) submit an annual service provider educational training schedule to HSD or its designee that includes the scheduled trainings for its network providers; the CLTS MCO/SE shall provide HSD or its designee with evidence, when requested, of ongoing provider educational activities scheduled throughout the year and throughout the state; evidence of such activities may include: a provider education schedule of events held throughout the state; provider manuals distributed to contracted providers and updated at least quarterly; publications, such as brochures and newsletters; media, such as films, videotaped presentations and seminars; and schedules of classroom instruction.

C. The CLTS MCO/SE shall maintain and continue these activities with its network providers throughout the term of the CLTS MCO/SE provider contractual relationship.

[8.307.6.18 NMAC - N, 8-1-08]

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

[8.307.6.19 NMAC - N, 8-1-08]

HISTORY OF 8.307.6 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG TERM SERVICES
PART 7 BENEFIT PACKAGE

8.307.7.1 ISSUING AGENCY: Human Services Department

[8.307.7.1 NMAC - N, 8-1-08]

8.307.7.2 SCOPE: This rule applies to the general public.

[8.307.7.2 NMAC - N, 8-1-08]

8.307.7.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.

[8.307.7.3 NMAC - N, 8-1-08]

8.307.7.4 DURATION: Permanent

[8.307.7.4 NMAC - N, 8-1-08]

8.307.7.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.

[8.307.7.5 NMAC - N, 8-1-08]

8.307.7.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.

[8.307.7.6 NMAC - N, 8-1-08]

8.307.7.7 DEFINITIONS: See 8.307.1.7 NMAC.

[8.307.7.7 NMAC - N, 8-1-08]

8.307.7.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.

[8.307.7.8 NMAC - N, 8-1-08]

8.307.7.9 BENEFIT PACKAGE: This part defines the medicaid benefit package for which the coordinated long-term services managed care organization (CLTS MCO) shall be paid fixed per-member per-month payment rates. The CLTS MCO shall cover these services. The CLTS MCO shall not delete benefits from the medicaid-defined benefit package. The CLTS MCO must utilize service providers licensed in accordance with state and federal requirements to deliver services.

[8.307.7.9 NMAC - N, 8-1-08]

8.307.7.10 MEDICAL ASSISTANCE DIVISION PROGRAM POLICY MANUAL: The medical assistance division program policy manual contains a detailed explanation of the services covered by medicaid, limitations to and exclusions of covered services, and services that are not covered by medicaid. The manual is the official source of information on covered and noncovered services. The CLTS MCO shall determine its own utilization management (UM) protocols that are based on reasonable medical evidence and are not bound by those found in the medicaid program manual. The human services department (HSD) or its designee must review and approve the CLTS MCO's UM protocols.
[8.307.7.10 NMAC - N, 8-1-08]

8.307.7.11 SERVICES INCLUDED IN THE COORDINATED LONG-TERM SERVICES PROGRAM BENEFIT PACKAGE: The CLTS MCO must provide a comprehensive, coordinated, and fully integrated system of health care, long-term services, and social and community services to its members. The following are state plan services provided under the authority of the 1915(b) waiver and are available to all CLTS members.

A. **Ambulatory surgical services (CLTS MCO):** The benefit package includes surgical services rendered in an ambulatory surgical center setting, as set forth in 8.324.10 NMAC, *Ambulatory Surgical Center Services*.

B. **Anesthesia services (CLTS MCO):** The benefit package includes anesthesia and monitoring services necessary for the performance of surgical or diagnostic procedures, as set forth in 8.310.5 NMAC, *Anesthesia Services*.

C. **Audiology services (CLTS MCO):** The benefit package includes audiology services, as set forth in 8.324.6 NMAC, *Hearing Aids and Related Evaluation*.

D. **Case management services:** The benefit package includes the following case management services:

(1) **Case management services for pregnant women and their infants (CLTS MCO only):** Case management services provided to pregnant women up to 60 days following the end of the month of the delivery, as set forth in 8.326.3 NMAC, *Case Managements Services for Pregnant Women and Their Infants*;

(2) **Case management services for traumatically brain injured adults (CLTS MCO only):** Case management services provided to adult members (21 years of age or older) who are traumatically brain injured, as set forth in 8.326.6 NMAC, *Case Management Services for Traumatically Brain Injured Adults*;

(3) **Case management services for children up to the age of three (CLTS MCO only):** Case management services provided to children up to the age of three who are medically at risk due to family conditions and not developmentally delayed, as detailed in 8.326.6 NMAC, *Case Management Services for Children Up to Age Three.*

(4) **Case management services for the medically at risk (CLTS MCO):** Case management services for individuals who are under 21 and are medically at risk for physical or behavioral health conditions, as set forth in 8.320.5 NMAC, *EPSDT Case Management*. "Medically at risk" is defined as those individuals who have a diagnosed physical or behavioral health condition that has a high probability of impairing their cognitive, emotional, neurological, social, behavioral, or physical development.

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

(6) **Case management services for the chronically mentally ill (SE only):** Case management services provided to adults who are 18 years of age or older and who are chronically mentally ill, as detailed in 8.326.4 NMAC, *Case Management Services for the Chronically Mentally Ill.*

E. **Dental services (CLTS MCO):** The benefit package includes dental services, as set forth in 8.310.7 NMAC, *Dental Services*.

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

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

H. **Durable medical equipment and medical supplies (CLTS MCO):** The benefit package includes the purchase, delivery, maintenance, and repair of equipment, oxygen, and oxygen administration equipment, nutritional products, disposable diapers, and disposable supplies essential for the use of the equipment, as set forth in 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies.*

I. **Emergency services (CLTS MCO/SE):** The benefit package includes emergency and post-stabilization care services. Emergency services are inpatient and outpatient services that are furnished by a qualified service provider and that are needed to evaluate or stabilize an emergency condition. An emergency condition shall meet the definition of emergency, as set forth in 8.307.1.7 NMAC, *definitions*. The CLTS MCO shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. Emergency services shall be provided in accordance with Subsection F of 8.307.7.11 NMAC, *diagnostic imaging and therapeutic radiology services*. Post-stabilization care services are covered services related to an emergency condition that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition, such that within reasonable medical probability, no material deterioration of the member's condition is likely to result from or occur during discharge of the member or transfer of the member to another facility.

J. **EPSDT services (CLTS MCO/SE):** The benefit package includes the delivery of the federally mandated early and periodic screening, diagnosis and treatment (EPSDT) services set forth in 8.320.2 NMAC, *EPSDT Services*, and the following:

(1) **EPSDT private duty nursing (CLTS MCO):** Private duty nursing for the EPSDT population, as set forth in 8.323.4 NMAC, *EPSDT Private Duty Nursing Services*. The services shall be delivered in the member's home or the school setting;

(2) **EPSDT personal care (CLTS MCO):** Medically necessary personal care services furnished to members under 21 years of age as part of EPSDT, as set forth in 8.323.2 NMAC, *EPSDT Personal Care*

Services;

(3) **Tot-to-teen health checks (CLTS MCO):** The CLTS MCO shall adhere to the periodicity schedule and ensure that eligible members receive EPSDT screens (tot-to-teen health checks), including:

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

(b) development of a proactive approach to ensure that the services are received by members;

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

(d) development of a systematic communication process with the CLTS MCO's network providers regarding screens and treatment coordination for members;

(e) process to document, measure and ensure compliance with the periodicity schedule; and

(f) development of a proactive process to ensure the appropriate follow-up of evaluations, referrals or treatment, especially early intervention for mental health conditions, vision and hearing screens, and current immunizations.

K. **Health education and preventive services:** The CLTS MCO shall:

(1) provide a continuous program of health education without cost to its members. Such a program includes publications, media, presentations, and classroom instruction;

(2) provide programs of wellness education;

(3) make preventive service available to members; the CLTS MCO shall periodically remind and encourage members to use benefits, including physical examinations, that are available and designed to prevent illness;

(4) initiate targeted prevention initiatives for members with acute and chronic disease; and

(5) develop policies and procedures that encourage the proactive performance of home safety evaluations for all at-risk members transitioning from institutions to community settings.

L. **Home health services (CLTS MCO):** The benefit package includes home health services, as set forth in 8.325.9 NMAC, *Home Health Services*.

M. **Hospice services (CLTS MCO):** The benefit package includes hospice services, as set forth in 8.325.4 NMAC, *Hospice Care Services.*

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

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

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

Q. **Nursing facility services (CLTS MCO):** The benefit package includes services provided in nursing facilities or hospital swing beds to members expected to reside in those facilities, as set forth in MAD-731, *Nursing Facilities*, and MAD-723, *Swing Bed Hospital Services*.

R. **Nutritional services (CLTS MCO):** The benefit package includes nutritional services furnished to pregnant women and children, as set forth in 8.324.9 NMAC, *Nutritional Services*.

S. **Personal care option (PCO) services (CLTS MCO):** The benefit package includes PCO services, as set forth in 8.315.4 NMAC, *Personal Care Option Services*.

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

(1) The CLTS MCO's preferred drug list (PDL) shall use the following guidelines:

(a) there must be at least one representing drug for each of the categories in the first data bank blue book;

(b) generic substitution shall be based on "AB" rating or clinical need;

(c) for a multiple source, brand name product within a therapeutic class, the CLTS MCO may select a representative drug;

(d) the PDL shall follow the centers for medicare and medicaid services (CMS) special guidelines relating to drugs used to treat HIV infection;

(e) the PDL shall include coverage of certain over the counter (OTC) drugs by a licensed practitioner; and

(f) the CLTS MCO shall implement an appeals process for service providers who believe that an exception to the PDL should be made for an individual member.

(2) The CLTS MCO shall use a PDL developed with consideration of the clinical efficiency, safety and cost effectiveness of drug items, and shall provide medically appropriate drug therapies for members. Drug items not on the PDL must be considered for coverage on a prior authorization basis. Atypical antipsychotic med-

ications must be available in the same manner as conventional antipsychotic medications for the treatment of severe mental illness, including schizophrenia, clinical depression, bipolar disorder, anxiety-panic disorder, and obsessive-compulsive disorder. Upon development, the CLTS MCO will be required to deliver its pharmacy benefit package using a single medicaid PDL.

(3) The CLTS MCO shall coordinate as necessary with the single statewide entity (SE) when administering pharmacy services, to ensure that member and service provider questions are directed appropriately. The CLTS MCO shall edit pharmacy claims to ensure that any authorizations given and claims paid are within the scope of the responsibility of the CLTS MCO or the CLTS MCO's pharmacy subcontractor, and shall inform members or providers when the claims fall under the scope of responsibility of the SE. Such determinations will be based primarily on the prescriber and other criteria as provided by the state.

(4) The CLTS MCO shall maintain written policies and procedures governing its drug utilization review (DUR) program, in compliance with federal and state law and regulations.

(5) The CLTS MCO shall coordinate the delivery of the pharmacy benefit when medicare part D is the primary coverage.

(6) The CLTS MCO shall ensure that any member who takes nine or more different prescription medications has their medications reviewed by a medical clinician for appropriateness and the identification and correction of potentially harmful practices, and shall document this review in the member's chart at least every six months.

U. **Physical health services (CLTS MCO):** The benefit package includes primary (including those provided in school-based settings) and specialty physical health services provided by a licensed practitioner and performed within their scope of practice, as defined by state law and set forth in 8.310.2.9 NMAC, *medical services providers*; 8.310.9 NMAC, *Midwife Services*, including attending out-of-hospital births and other related birthing services performed by certified nurse midwives or direct-entry midwives licensed by the state of New Mexico, who are either: (1) validly contracted with and fully credentialed by the CLTS MCO, or (2) validly contracted with the HSD medical assistance division and participate in HSD's birthing options program; 8.310.11 NMAC, *Podiatry Services*; 8.310.3 NMAC, *Rural Health Clinic Services*; and 8.310.4 NMAC, *Federally Qualified Health Center Services*.

V. **Pregnancy termination services (CLTS MCO):** The benefit package includes coverage of pregnancy terminations for rape, incest and endangerment to the life of the mother, as allowed in accordance with 42 CFR Section 441.202. A certification from the network provider must be provided prior to payment. Medically necessary pregnancy terminations that do not meet the requirements of 42 CFR Section 441.202 are excluded from the capitation payment made to the CLTS MCO, and shall be reimbursed solely from state funds pursuant to the provisions of 8.325.7 NMAC, *Pregnancy Termination Procedures*.

W. **Preventive health services (CLTS MCO):** The benefit package includes preventive health services, including:

(1) **Immunizations:** The CLTS MCO shall ensure that, within six months of enrollment, members are current with immunizations according to the type and schedule provided by the most recent version of the recommendations of the advisory committee on immunization practices (ACIP) of the centers for disease control and prevention, public health service, U.S. department of health and human services. This may be done by providing the necessary immunizations or by verifying the immunization history by a method deemed acceptable by the ACIP. "Current" is defined as no more than four months overdue.

(2) **Screens:** The CLTS MCO shall ensure that, to the extent possible, asymptomatic members receive and are current for at lest the following screening services within six months of enrollment or within six months of a change in the standard. The CLTS MCO shall require its network providers to perform the appropriate interventions based on the results of the screens. "Current" is defined as no more than four months overdue. The CLTS MCO shall ensure that clinically appropriate follow-up or intervention is performed when indicated by the screening results.

(a) **Screening for breast cancer:** Female members age 50-69 who are not at high risk for breast cancer shall be screened annually with mammography and a clinical breast examination. Female members at high risk for developing breast cancer shall be screened as often as clinically indicated.

(b) **Screening for cervical cancer:** Female members with a cervix shall receive papanicolaou (PAP) testing starting at the onset of sexual activity, but at least by 18 years of age, and every three years thereafter until reaching 65 years of age, if prior testing has been consistently normal and the member has been confirmed to be not at high risk. If the member is at high risk, the testing frequency shall be at least annual.

(c) **Screening for colorectal cancer:** Members age 50 and older at normal risk for colorectal cancer shall be screened with annual fecal occult blood testing or sigmoidoscopy at a periodicity determined by the CLTS MCO.

(d) **Blood pressure measurement:** Members of all ages shall receive a blood pressure measurement as medically indicated.

(e) **Serum cholesterol measurement:** Male members age 35-65 and female members age 45-65 who are at normal risk for coronary heart disease shall receive serum cholesterol measurement every five years. Those members with multiple risk factors shall also receive HDL-C measurement.

(f) **Screening for obesity:** All members shall receive annual body weight and height measurements to be used in conjunction with a calculation of the body mass index or referenced to a table of recommended weights.

(g) **Screening for elevated lead levels:** Members age nine to 15 months (ideally 12 months old) shall receive a blood lead measurement at least once.

(h) **Screening for diabetes:** Members shall receive a fasting or two-hour post-prandial serum glucose measurement at least once.

(i) **Screening for tuberculosis:** Members shall receive a tuberculin skin test based on the level of individual risk for development of the infection.

(j) **Screening for rubella:** Female members of childbearing ages shall be screened for rubella susceptibility by history of vaccination or by serology at their first clinical encounter in an office setting.

(k) **Screening for visual impairment:** Members three to four years of age shall be screened at least once for amblyopia and strabismus by physical examination and a stereo acuity test.

(l) **Screening for hearing impairment:** Members age 50 and older shall be routinely screened for hearing impairment by questioning them about their hearing.

(m) **Screening for problem drinking and substance abuse:** Adolescent and adult members shall be screened at least once by a careful history of alcohol use or the use of a standardized screening questionnaire, such as the alcohol use disorders identification test (AUDIT) or the four-question CAGE instrument and the substance abuse screening and severity inventory (SASSI). The frequency of screening shall be determined by the results of the first screen and other clinical indications. Members shall be referred to the SE as warranted.

(n) **Prenatal screening:**

Pregnant members shall be screened for preeclampsia, D (Rh) incompatibility, down syndrome, neural tube defects, hemoglobinopathies, and vaginal and rectal group B streptococcal infection; and counseled and offered testing for HIV.

(o) **Newborn screening:** At a minimum, newborn members shall be screened for phenylketonuria, congenital hypothyroidism, galactosemia, and any other congenital disease or condition specified in accordance with department of health regulations, specifically 7 NMAC 30.6, *Newborn genetic screening program*.

(p) **Behavioral health screening:** During an encounter with a primary care provider (PCP), a behavioral health screen shall occur.

(3) **Tot-to-teen health checks:** The CLTS MCO shall operate a tot-to-teen health check program for members up to 21 years of age to ensure the delivery of federally mandated EPSDT services. Within six months of enrollment, the CLTS MCO shall endeavor to ensure that eligible members are current according to the screening schedule for EPSDT services.

(4) **Counseling services:** The CLTS MCO shall provide to applicable asymptomatic members counseling on the following unless member refusal is documented: to prevent tobacco use; to promote physical activity; to promote a healthy diet; to prevent osteoporosis and heart disease in menopausal female members; to prevent motor vehicle injuries; to prevent household and recreational injuries; to prevent dental and periodontal disease; to prevent HIV infection and other sexually transmitted diseases; and to prevent unintended pregnancies.

(5) **Health advisor hotline:** The CLTS MCO shall provide a toll-free health advisor hotline, which shall provide at least the following:

(a) general health information on topics appropriate to the various medicaid populations, including those with severe and chronic conditions;

(b) clinical assessment and triage to evaluate the acuity and severity of the member's symptoms and make the clinically appropriate referral; and

(c) pre-diagnostic and post-treatment service decision assistance based on symptoms.

(6) **Family planning policy (CLTS MCO):** The CLTS MCO shall have a written family planning policy to ensure that members of the appropriate age of both sexes who seek family planning services shall be provided with counseling pertaining to the following: methods of contraception; evaluation and treatment of infertility; risk reduction practices for HIV and other sexually transmitted diseases; options for pregnant members who do not wish to keep a child; and options for pregnant members who may wish to terminate the pregnancy.

(7) **Prenatal care program (CLTS MCO):** The CLTS MCO shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal services consistent with the standards of the American college of obstetrics and gynecology. The program shall include at least the following:

(a) educational outreach to all members of childbearing ages;

(b) prompt and easy access to obstetrical services, including providing an office visit with a practitioner within three weeks of having a positive pregnancy test (laboratory or home) unless earlier care is clinically indicated;

(c) risk assessment of all pregnant members to identify high risk cases for special management;

(d) counseling that strongly advises voluntary testing for HIV;

(e) case management services to address the special needs of members who have a high risk pregnancy, especially if risk is due to psychosocial factors such as substance abuse or teen pregnancy;

(f) screening for determination of need of a post-partum home visit; and

(g) coordination with other services in support of good prenatal care, including transportation and other community services and referral to an agency that dispenses free or reduced price baby car seats.

X. **Prosthetics and orthotics (CLTS MCO):** The benefit package includes prosthetic and orthotic services, as set forth in 8.324.8 NMAC, *Prosthetics and Orthotics*.

Y. **Rehabilitation services (CLTS MCO):** The benefit package includes inpatient and outpatient hospital and outpatient physical, occupational and speech therapy services, as set forth in 8.325.8 NMAC, *Rehabilitation Services*; and licensed speech and language pathology services furnished under the EPSDT program, as set forth in 8.323.5 NMAC, *Licensed Speech and Language Pathologists*.

Z. **Reproductive health services (CLTS MCO):** The benefit package includes reproductive health services, as set forth in 8.325.3 NMAC, *Reproductive Health Services*. The CLTS MCO shall provide members with sufficient information to allow them to make informed choices, including: the types of family planning services available; the member's right to access these services in a timely and confidential manner; and the freedom to choose a qualified family planning provider. A female member shall have the right to self-refer to a women's health specialist within the CLTS MCO's provider network for covered services necessary to provide women's routine and preventive health care services. This right o self-refer is in addition to the member's designated source of primary care if that source is not a women's health specialist.

AA. **School-based services (CLTS MCO/SE):** The benefit package includes services provided in schools, excluding those specified in the individualized education plan (IEP) or individualized family service plan (IFSP), as set forth in 8.320.6 NMAC, *School-Based Services for Recipients Under 21 Years of Age*.

BB. **Service coordination:** The benefit package includes service coordination that is person-centered and intended to support members in pursuing their desired life outcomes by assisting them in accessing support and services necessary to achieve the quality of life that they desire in a safe and healthy environment. Service coordination assists members in gaining access to needed coordinated long-term services program waiver services; medicaid state plan services; and medical, social, educational and other services, regardless of the funding source for the services to which access is needed.

CC. **Telehealth services (CLTS MCO/SE):** The benefit package includes telehealth services as set forth in 8.310.13 NMMAC, *Telehealth Services.*

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

EE. **Transportation services (CLTS MCO):** The benefit package includes transportation services such as ground ambulance, air ambulance, taxicab or handivan, commercial bus, commercial air, meal, and lodging services, as indicated for medically necessary physical and behavioral health services, as set forth in 8.324.7 NMAC *Transportation Services*. In addition, the CLTS MCO must abide by New Mexico law and regulations, specifically NMSA 1978 Section 65-2-97(F), stating that rates paid by the CLTS MCO to transportation providers are not subject to and are exempt from New Mexico public regulation commission approved tariffs. The CTLS MCO is also required to coordinate, manage and be financially responsible for

the delivery of the transportation benefit to members receiving physical health services or behavioral health services. The CTS MCO shall coordinate with the SE as necessary to perform this function. Such coordination shall include:

(1) receiving information from and providing information to the SE regarding members and service providers;

(2) meeting with the SE to resolve provider and member issues to improve services, communication and coordination;

(3) contacting the SE, as necessary, to provide quality transportation services; and

(4) maintaining and distributing statistical information and data as may be required.

FF. **Vision services (CLTS MCO):** The benefit package includes vision services, as set forth in 8.310.6 NMAC, *Vision Care Services*.

GG. The following are services provided under the 1915 (c) waiver to CLTS members who meet specific criteria.

(1) **Adult day health services (CLTS MCO):** The benefit package includes adult day health services, which are generally provided for two or more hours per day on a regularly scheduled basis, for one or more days per week, by a licensed adult day-care, community-based facility that offers health and social services to assist eligible members in achieving optimal functioning. Private duty nursing services and skilled maintenance therapies (physical, occupational and speech therapies) may be provided in conjunction with adult day health services by the adult day health service provider or by another service provider. Private duty nursing services and skilled maintenance therapies must be provided in a private setting at the facility.

(2) **Assisted living services (CLTS MCO):** The benefit package includes assisted living services, which are residential services that include personal support services, companion services, and assistance with medication administration, as set forth in department of health regulations 7.8.2 NMAC, *Residential Health Facilities*.

(3) **Community transition goods and services, and community relocation specialist services (CLTS MCO):** The benefit package includes community transition and relocation specialist services designed to move individuals, where appropriate, from an institutional setting to home and community-based programs, as detailed in the coordinated long-term services contract.

(4) **Emergency response services (CLTS MCO):** The benefit package includes emergency response services, including the provision of an electronic device that enables members to secure help in an emergency. The member may also wear a portable "help" button to allow for mobility. The system is connected to the member's telephone and programmed to signal a response center when the "help" button is activated. The response center must be staffed by trained professionals. Emergency response services include installing, testing and maintaining equipment; training members, caregivers and first responders on the use of the equipment; 24-hour monitoring for alarms; checking systems monthly, or more frequently, if warranted by electrical outages, severe weather or other conditions; and reporting member emergencies and changes in the member's condition that may affect service delivery. Emergency categories consist of emergency response, emergency response high need, and emergency response installation/disconnect.

(5) **Environmental modifications (CLTS MCO):** The benefit package includes environmental modifications, including the purchase or installation of equipment or the making of physical adaptations to a member's residence that are necessary to ensure the health, welfare and safety of the member, or to enhance the member's level of independence.

(a) Adaptations include: installing ramps and grab-bars; widening doorways/hallways; installing specialized electric and plumbing systems to accommodate medical equipment and supplies; installing lifts or elevators; modifying bathroom facilities; adapting turnaround spaces; making specialized accessibility and safety adaptations; making household additions; installing trapeze and mobility tracks for home ceilings; installing automatic door openers and doorbells; installing voice, light or motion-activated electronic devices; making fire safety adaptations; installing air filtering devices; making heating/cooling adaptations; installing glass substitutes for windows and doors; installing modified switches, outlets or environmental controls for home devices; and installing alarm and alert systems or signaling devices.

(b) All environmental modifications shall be provided in accordance with applicable federal and state laws and regulations, and local building codes. The CLTS MCO must ensure that proper design criteria is used in planning and designing the adaptation; provide or secure licensed contractor(s) or approved vendor(s) to provide construction/remodeling services; provide administrative and technical oversight of construction projects; provide consultants to family members, waiver providers, and contractors concerning environmental modification projects; and inspect the final environmental modification project to ensure that the adaptations meet the approved plan.

(6) **Private duty nursing services (CLTS MCO):** The benefit package includes private duty nursing services, including activities, procedures and treatment for a physical condition, physical illness or chronic disability. Services include: medication management, administration and teaching; aspiration precautions; feeding tube management; gastrostomy and jejunostomy; skin care; weight management; urinary catheter management; bowel and bladder care; wound care; health education; health screening; infection control; environment management for safety; nutrition management; oxygen management; seizure management and precautions; anxiety reduction; staff supervision; and behavior and self-care assistance.

(7) **Respite services (CLTS MCO):** The benefit package includes respite services provided to members who are unable to care for themselves. Respite services are provided on a short-term basis because of the absence or need for relief of those persons normally providing the services. Respite services may be provided in a member's home or in the community. Services include: assistance with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation, and eating); enhancing self-help skills; providing opportunities for leisure, play and other recreational activities; and allowing community integration.

(8) **Skilled maintenance therapy services (CLTS MCO):** The benefit package includes skilled maintenance therapy services, including occupational, physical and speech language therapy services.

[8.307.7.11 NMAC - N, 8-1-08]

8.307.7.12 BEHAVIORAL HEALTH SERVICES: Behavioral health services provided by the CLTS MCO's network providers will be covered by the CLTS MCO, even when the primary diagnosis is a behavioral health diagnosis. Facility costs, including emergency room costs, will be covered by the CLTS MCO unless there is a specific psychiatric revenue code on the facility claim form. Any professional services provided by a behavioral health service provider in an emergency room or in an inpatient or outpatient hospital setting will be covered by the SE. Any services provided by a physical health service provider in an emergency room or in an inpatient setting will be covered by the CLTS MCO. The SE will cover outpatient hospital services that require the use of a psychiatrist or psychologist revenue code for billing. Pharmacy claims prescribed by a physical health service provider will be covered by the CLTS MCO.

[8.307.7.12 NMAC - N, 8-1-08]

8.307.7.13 BEHAVIORAL HEALTH SERVICES INCLUDED IN THE BENEFIT PACKAGE FOR ADULTS AND CHILDREN. The SE shall cover the following medicaid services. If, at any time, other medicaid behavioral health services are included in the state plan or a state plan amendment, the SE shall cover those services also.

A. **Inpatient hospital services:** The benefit package includes inpatient hospital psychiatric services provided in general hospital units and prospective payment system (PPS)-exempt units in a general hospital as detailed in 8.311.2 NMAC, *Hospital Services*.

B. **Hospital outpatient services:** The benefit package includes outpatient psychiatric and partial hospitalization services provided in PPS-exempt units of general hospitals as detailed in 8.311.4 NMAC, *Outpatient Psychiatric Services and Partial Hospitalization*.

C. **Outpatient health care professional services:** The benefit package includes outpatient health care services, as detailed in 8.310.8 NMAC, *Mental Health Professional Services*.

D. **Comprehensive community support services:** The benefit package includes comprehensive community support services as detailed in 8.315.6 NMAC, *Comprehensive Community Support Services.*

E. **Assertive community treatment services (ACT):** The benefit package includes assertive community treatment services for members eighteen (18) years of age and older as detailed in 8.315.5 NMAC, *Assertive Community Treatment Services*.

[8.307.7.13 NMAC - N, 8-1-08]

8.307.7.14 BEHAVIORAL HEALTH SERVICES INCLUDED IN THE CLTS BENEFIT PACKAGE FOR CHILDREN ONLY: The SE shall provide the following medicaid services. The benefit package includes prevention, screening, diagnostic, ameliorative services and other medically necessary behavioral health care and substance abuse treatment or services for medicaid members under 21 years of age whose need for behavioral health services is identified by a licensed health care provider or during an EPSDT screen. All behavioral health care services shall be provided in accordance with the current New Mexico Children's Code and the Children's Mental Health and Developmental Disabilities Act, NMSA Section 32A-6-1 to 32A-6-22. The services include the following:

A. **Inpatient hospitalization in free standing psychiatric hospitals:** The benefit package includes inpatient services in free standing psychiatric hospitals as detailed in 8.321.2 NMAC, *Inpatient Psychiatric Care in Freestanding Psychiatric Hospitals*.

B. **Accredited residential treatment center services:** The benefit package includes accredited residential treatment services as detailed in 8.321.3 NMAC, *Accredited Residential Treatment Center Services*.

C. **Nonaccredited residential treatment centers and group homes:** The benefit package includes residential treatment services as detailed in 8.321.4 NMAC, *Non-Accredited Residential Treatment Centers and Group Homes*.

D. **Treatment foster care:** The benefit package includes treatment foster care services as detailed in 8.322.2 NMAC, *Treatment Foster Care*.

E. **Treatment foster care II:** The benefit package includes treatment foster care II, as detailed in 8.322.5 NMAC, *Treatment Foster Care II.*

F. **Outpatient and partial hospitalization services in freestanding psychiatric hospital:** The benefit package includes outpatient and partial hospitalization services provided in freestanding psychiatric hospitals, as detailed in 8.321.5 NMAC, *Outpatient and Partial Hospitalization Services in Freestanding Psychiatric Hospitals*.

G. **Day treatment services:** The benefit package includes day treatment services, as detailed in 8.322.4 NMAC, *Day Treatment Services*.

H. **Behavior management skills development services (BMSDS):** The benefit package includes behavior management services, as detailed in 8.322.3 NMAC, *Behavior Management Skills Development Services*.

I. **School-based services:** The benefit package includes counseling, evaluation and therapy furnished in a school-based setting, but not when specified in the individual education plan (IEP) or the individualized family service plan (IFSP), as detailed in 8.320.6 NMAC, *School-Based Services for Recipients Under 21 Years of Age*.

J. **Licensed alcohol and drug abuse counselors:** The benefit package includes alcohol and drug abuse counseling, as detailed in MAD 746.6, *Licensed Alcohol and Drug Abuse Counselors*.

K. **Multi-systemic therapy services:** The benefit package includes multi-systemic therapy services, as detailed in 8.322.6 NMAC, *Multi-Systemic Therapy Services.*

[8.307.7.14 NMAC - N, 8-1-08]

8.307.7.15 BEHAVIORAL HEALTH SERVICES INCLUDED IN THE BENEFIT PACKAGE FOR ADULTS ONLY: The benefit package includes psychosocial rehabilitation, as detailed in 8.315.3 NMAC Psychosocial Rehabilitation Services, and shall be provided by the SE, in accordance with the New Mexico Mental Health and Developmental Disabilities Code, NMSA Sections 43-1-1 to 43-1-25.

[8.307.7.15 NMAC - N, 8-1-08]

8.307.7.16 SERVICES EXCLUDED FROM THE CLTS BENEFIT PACKAGE: The following services are not included in the coordinated long-term services program benefit package:

A. services provided in intermediate care facilities for the mentally retarded (ICF/MR), as set forth in 8.313.2 NMAC, *Intermediate Care Facilities for the Mentally Retarded*;

B. emergency services to undocumented aliens, as set forth in 8.325.10 NMAC, *Emergency Services for Undocumented Aliens*;

C. experimental or investigational procedures, technologies or non-drug therapies, as set forth in 8.325.6 NMAC, *Experimental or Investigational Procedures, Technologies or Non-Drug Therapies*;

D. case management services provided by the children, youth and families department that are defined as child protective services case management, as set forth in 8.320.5 NMAC, *EPSDT Case Management*;

E. case management services provided by the aging and long-term services department, as set forth in 8.326.7 NMAC, *Adult Protective Services Case Management*;

F. case management services provided by the children, youth and families department, as set forth in 8.326.8 NMAC, *Case Management Services for Children Provided by Juvenile Probation and Parole Officers*;

G. services provided in the schools and specified in the IEP or IFSP, as set forth in 8.320.6 NMAC, *School-Based Services for Recipients Under 21 Years of Age*; and

H. services provided under the home and community-based waiver services programs, as set forth in 8.314.2 NMAC, *Disabled and Elderly Home and Community-Based Services Waiver*, the medically fragile waiver, HIV/AIDS waiver, developmentally disabled waiver, and mi via waiver.

[8.307.7.16 NMAC - N, 8-1-08]

8.307.7.17 VALUE-ADDED SERVICES: See 8.307.17 NMAC

[8.307.7.17 NMAC - N, 8-1-08]

HISTORY OF 8.307.7 NMAC:

[RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG TERM SERVICES
PART 8 QUALITY MANAGEMENT

8.307.8.1 ISSUING AGENCY: Human Services Department
[8.307.8.1 NMAC - N, 8-1-08]

8.307.8.2 SCOPE: This rule applies to the general public.
[8.307.8.2 NMAC - N, 8-1-08]

8.307.8.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute.
[8.307.8.3 NMAC - N, 8-1-08]

8.307.8.4 DURATION: Permanent
[8.307.8.4 NMAC - N, 8-1-08]

8.307.8.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.8.5 NMAC - N, 8-1-08]

8.307.8.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.8.6 NMAC - N, 8-1-08]

8.307.8.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.8.7 NMAC - N, 8-1-08]

8.307.8.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.8.8 NMAC - N, 8-1-08]

8.307.8.9 QUALITY MANAGEMENT: The human services department (HSD) recognizes that strong programs of quality improvement (QI) and assurance help ensure that better services are delivered in a cost-effective manner to the member. Under the terms of the medicaid coordinated long-term services contract, quality management (QM) programs are incorporated into health service delivery and administrative systems.
[8.307.8.9 NMAC - N, 8-1-08]

8.307.8.10 EXTERNAL QUALITY REVIEW: The state shall retain the services of an external quality review organization (EQRO) in accordance with the Social Security Act Section 1902(a)(30)(C). The coordinated long-term services managed care organizations (CLTS MCOs) shall cooperate fully with the EQRO and demonstrate adherence to HSD's regulations and quality standards. The EQRO shall not be a competitor of the CLTS MCO. The CLTS MCO shall utilize technical assistance and guidelines offered by the EQRO, when recommended or directed by the state.
[8.307.8.10 NMAC - N, 8-1-08]

8.307.8.11 BROAD STANDARDS:

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

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

C. **Collection of clinical data:** For indicators requiring clinical data as a data source, the CLTS MCO shall collect and utilize a sample of clinical records sufficient to produce statistically valid results. The size of the sample shall support stratification of the population by a range of demographic and clinical factors pertinent to the special vulnerable populations served. These populations shall include, but are not limited to, ethnic minorities, homeless, pregnant women, gender and age-based populations.

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

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

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

G. The CLTS MCO agrees to comply with all applicable standards, orders and regulations issued pursuant to the Clean Air Act, 42 U.S.C. Section 7401 et. seq., and the Federal Water Pollution Control Act, as amended and codified at 33 U.S.C. Section 1251 et. seq. In addition to any and all remedies or penalties set forth in this agreement, any violation of this provision shall be reported to the US department of health and human services (HHS) and the appropriate regional office of the environmental protection agency.
[8.307.8.11 NMAC - N, 8-1-08]

8.307.8.12 STANDARDS FOR QUALITY MANAGEMENT AND IMPROVEMENT:

A. **Program structure:** Quality management (QM) is an integrated approach that links knowledge, structure and processes together throughout the CLTS MCO/SE's system to assess and improve quality. The goal of quality improvement (QI) activities is to improve the quality of clinical care and services provided to members in the areas of health service delivery and supportive administrative systems. The CLTS MCO /SE's QM and QI structures and processes shall be planned, systematic, clearly defined, and at least as stringent as federal requirements. Responsibilities shall be assigned to appro-

priate individuals. The CLTS MCO/SE shall submit its comprehensive QM/QI plan for the coming year on an annual basis, as well as a comprehensive QM/QI evaluation of the previous year's achievement and performance of its QM/QI goals and initiatives. The QI program for the CLTS MCO/SE shall be reviewed and approved by HSD or its designee annually. The CLTS MCO/SE's QI/QM activities shall demonstrate the linkage of quality improvement projects to findings from multiple quality evaluations, such as the external quality review annual evaluation; opportunities for improvement identified through either the annual HEDIS indicators or state defined performance measures; the annually required consumer satisfaction surveys and service provider surveys; and any findings identified by an accreditation body such as NCQA.

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

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

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

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

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

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

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

(8) The program description shall address QI for all major demographic groups within the CLTS MCO or SE.

(9) The program description shall address member satisfaction and include methods of collecting and evaluating information, including the consumer assessment of health plans survey (CAHPS), a survey identifying opportunities for improvement, implementing and measuring effectiveness of intervention, and informing service providers of results. The CLTS MCOs shall actively solicit through their consumer advisory board or outreach activities the input of members in the development of target protocols and procedures and other feedback regarding the MCO's quality management and improvement system.

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

(11) The program description/work plan shall address activities aimed at addressing culture-specific health beliefs and behaviors and risk conditions, and shall respond to member and service provider requests for culturally appropriate services. Culturally appropriate services may include: language and translation services, dietary practices, individual and family interaction norms, and the role of the family in compliance with long-term treatment.

(12) The program description/work plan shall address activities to improve the health status of members with chronic conditions, including identification of such members; implementation of services and programs to assist such members in managing their conditions, including behavioral health; and informing service providers about the programs and services for members assigned to them.

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

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

(15) The program description/work plan shall include: objectives for the year; activities regarding quality of clinical care and services; timelines; responsible persons; planned monitoring for newly identified and previously identified issues; and an annual evaluation of the QI program.

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

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

(18) The QM/QI annual written evaluation submitted to HSD shall include a review of completed and continuing QI activities that address quality of clinical care and quality of service; determination and documentation of any demonstrated improvements in quality of care and service; and evaluation of the overall effectiveness of the QI program based on evidence of meaningful improvements (See Subsection J of 8.307.8.12 NMAC, *effectiveness of the QI program*).

(19) The program description/work plan shall include specific activities related to findings identified in the annual consumer and service provider surveys as areas that indicate targeted QI interventions and monitoring.

B. **Program operations:** The QI committee shall:

(1) recommend QI policy reviews, evaluate the results of QI activities, institute needed actions, and ensure follow-up as appropriate;

(2) have contemporaneous dated and signed minutes that reflect all QI committee decisions and actions;

(3) ensure that the CLTS MCO/SE's service providers participate actively in the QI activities;

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

(5) ensure that there is a linkage between the QM/QI program and other management activities, such as network changes, benefits redesign, practice feedback to service providers, member health education, and member services, which will be documented in progress reports submitted to HSD or its designee;

(6) ensure that there is evidence that the results of QI activities, performance improvement projects and reviews are used to improve quality; there will be evidence of communication and use of the results of QI activities, performance improvement projects and reviews, with appropriate individual and institutional service providers;

(7) ensure that the CLTS MCO/SE coordinated the QI program with performance monitoring activities throughout the organization, including but not limited to, its compliance with all quality standards and other specifications in the contract for medicaid coordinated long-term

services, such as compliance with state standards;

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

(9) ensure that stakeholders/members have an opportunity to provide input.

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

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

(1) recognition that opportunities for improvement are unlimited;

(2) assurance that the QI process is data driven;

(3) use of member and service provider input; and

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

E. **Member satisfaction:** The CLTS MCO/SE shall implement methods aimed at member satisfaction with the active involvement and participation of members and their families, whenever possible.

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

(2) The CLTS MCO/SE shall add questions about individuals with special health care needs (ISHCN) to all consumer surveys, as appropriate.

(3) The CLTS MCO/SE shall disseminate results of the member satisfaction survey to service providers, providers, the state, and CLTS MCO/SE members.

(4) The CLTS MCO shall cooperate with the state in conducting a network provider satisfaction survey.

(5) The CLTS MCO/SE shall evaluate member grievances and appeals for trends and specific problems, including behavioral health problems.

(6) The CLTS MCO/SE shall use input from the consumer advisory board to identify opportunities for improvement in the quality of CLTS MCO/SE performance.

(7) The CLTS MCO/SE shall implement interventions to improve its performance.

(8) The CLTS MCO/SE shall measure the effectiveness of the interventions.

(9) The CLTS MCO shall participate in the design of specific questions for the CAHPS adult and child surveys.

F. **Health management systems:**

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

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

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

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

(d) The CLTS MCO/SE shall proactively identify ISHCN who have or are at increased risk for a chronic physical or behavioral health condition.

(e) The CLTS MCO/SE shall inform and educate its service providers about the use of health management programs for CLTS MCO/SE members.

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

(g) The CLTS MCO/SE shall periodically update its service providers regarding best practices and on procedures for appropriate health service referrals.

(2) The CLTS MCO/SE shall pursue continuity of services for members. The CLTS MCO/SE shall:

(a) report changes in its provider network to HSD or its designee;

(b) have a defined health service delivery process to promote a high level of member compliance with follow-up appointments, consultations/referrals, and diagnostic laboratory, diagnostic imaging and other testing;

(c) have a defined process to ensure prompt member notification by its service providers of abnormal results of diagnostic laboratory, diagnostic imaging and other testing, and this will be documented in the medical record;

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

(e) ensure that all medically necessary referrals are arranged and coordinated by either the referring service provider or by the CLTS MCO/SE's service coordination unit;

(f) implement policies and procedures to ensure that continuity and coordination of services occur across practices, service provider sites and between CLTS MCO/SE; in particular, the CLTS MCO/SE shall coordinate, in accordance with applicable state and federal privacy laws, with other state agencies such as the department of health, the children youth and families department protective services and juvenile justice divisions, the corrections department community reentry services, and the schools; in addition, the SE shall coordinate services with all applicable state agencies comprising the collaborative; and

(g) assist and monitor the transitions between service providers for continuity of services in order to avoid abrupt changes in treatment plans and caregivers for members currently being served.

(3) At the request of a member or their legal guardian, the CLTS MCO/SE shall provide information to consumer/participants on options for converting coverage to a different insurance to members whose enrollment is terminated due to loss of med-

icaid eligibility, and this shall be documented.

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

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

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

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

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

(5) The CLTS MCO/SE shall distribute the guidelines to the appropriate service providers and to HSD or its designee.

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

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

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

(a) improve the ability to manage chronic illnesses/diseases in order to meet goals based on jointly established targets;

(b) provide comprehensive disease management for a minimum of two (2) chronic diseases using strategies consistent with nationally recognized disease management guidelines;

(c) submit cumulative data-driven measurements from each of its disease management programs to the state according to contract requirements; all disease management data submitted to the state shall be New Mexico medicaid-specific;

(d) submit to the state annually the CLTS MCO disease management plan, which includes a program description, overall program goals, measurable objectives, targeted interventions, and its methodology used to identify other diseases for potential disease management programs;

(e) submit to the state annually a quantitative evaluation of the efficacy of the prior year's disease management program; and

(f) demonstrate consistent improvement in the overall disease management program goals annually or maintain mutually agreed upon level of performance with a report to the state.

(9) The CLTS MCOs shall develop targets with protocols and procedures that address the needs of individuals with disabilities, who are not ill, and address quality-of-life enhancing targets needed by people with disabilities.

H. **Quality assessment and performance improvement:** The CLTS MCO/SE shall achieve required minimum performance levels, as established by HSD and the centers for medicare and medicaid services (CMS), on certain quality performance measures and projects. These required levels of performance would address a broad spectrum of key aspects of member care and services. These quality measures may change from year to year and may be used in part to determine the CLTS MCO/SE assignment algorithm. In addition, the CLTS MCO/SE shall provide HSD or its designee with copies of all studies performed for national accreditation. The CLTS MCO/SE shall achieve minimum performance levels set by HSD for each performance measure. The CLTS MCO/SE shall measure its performance, using claims, encounter data, and other predefined sources of information, and report its performance on each measure to HSD at a frequency to be determined by HSD. The SE shall annually provide HSD with copies of its QM/QI studies including its data analysis. The CLTS MCO shall:

(1) implement performance measures and tracking measures defined by HSD or its designee in collaboration with the CLTS MCO; the CLTS MCO shall monitor these measures on an ongoing basis and report results to HSD or its designee;

(2) identify and monitor performance measures and tracking measures of home and community-based service delivery, and implement activities designed to improve the coordination of CLTS services;

(3) demonstrate consistent and sustainable patterns of improvement from year to year in the overall member satisfaction survey results, disease management initiatives and performance measures;

(4) review outcome data at least quarterly for performance improvement recommendations and interventions; and

(5) provide mechanisms for monitoring, addressing and correcting any evidence of cost-shifting practices by network providers.

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

(1) implement interventions to improve service provider and system performance as appropriate;

(2) implement appropriate corrective interventions when it identifies individual occurrences of poor or substandard quality, especially regarding health and safety issues; and

(3) implement appropriate corrective interventions when it identifies underutilization or over-utilization.

J. **Effectiveness of the QI program:** The CLTS MCO/SE shall evaluate the overall effectiveness of its QI program and demonstrate improvements in the quality of clinical care and the quality of service to its members.

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

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

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

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

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

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

[8.307.8.12 NMAC - N, 8-1-08]

8.307.8.13 STANDARDS FOR UTILIZATION MANAGEMENT: New Mexico medicaid requires appropriate utilization management (UM) standards to be implemented and activities to be performed so that excellent services are provided in a coordinated fashion with neither over nor under-utilization. The CLTS MCO/SE's UM programs shall be based on standard external national criteria, where available, and established clinical criteria, that are congruent with HSD's medical necessity service definition as defined in 8.307.1.7

NMAC, *definitions*, and are applied consistently in UM decisions by the CLTS MCO/SE. The CLTS MCO/SE's UM program shall assign responsibility to appropriately qualified, educated, trained, and experienced individuals to manage the use of limited resources; maximize the effectiveness of services by evaluating clinical appropriateness; authorize the type and volume of services through fair, consistent and culturally competent decision making; and assure equitable access to services. These standards shall also apply to pharmacy utilization management including the formulary exception process.

A. **Program design:**

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

(2) A designated physician shall have substantial involvement in the design and implementation of the UM program.

(3) The description shall include the scope of the program; the processes and information sources used to determine benefit coverage; clinical necessity, appropriateness and effectiveness; policies and procedures to evaluate service coordination, discharge criteria, site of services, levels of care, triage decisions and cultural competence of service delivery; processes to review, approve and deny services; processes to evaluate service outcomes; and a plan to improve outcomes, as needed. The above service definitions are to be no less than the amount, duration and scope for the same services furnished to members under fee-for-service (FFS) medicaid, as set forth in 42 CFR Section 440.230. The member's individualized service plan (ISP) priorities and prolonged service authorizations applicable for individuals with chronic conditions shall be considered in the decision-making process.

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

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

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

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

(1) UM decisions shall be based on reasonable and scientifically valid utilization review criteria that are objective and measurable, insofar as practical.

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

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

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

(3) criteria for determination of medical appropriateness shall be clearly documented;

(4) the CLTS MCO/SE shall maintain evidence that it has reviewed the criteria at specified intervals and that the criteria have been updated, as necessary; and

(5) The CLTS MCO/SE shall state in writing how service providers can obtain UM criteria and shall provide criteria to its service providers upon request;

C. **Authorization of services:** For the processing of requests for initial and continuing authorization of services, the CLTS MCO/SE shall:

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

(2) require that its subcontractors have in place written policies and procedures;

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

(4) consult with requesting providers when appropriate to secure additional information.

D. **Use of qualified professionals:** The CLTS MCO/SE shall have written policies and procedures explaining how qualified health professionals shall assess the clinical information used to support UM decisions.

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

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

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

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

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

(1) **Precertification - routine:**

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

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

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

(2) **Precertification - urgent:**

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

(b) **Confirmation - denial:** For denial of urgent services, the CLTS

MCO/SE shall give the member and service provider written or electronic confirmation of the decision within two working days of making the decision. The CLTS MCO/SE shall provide written confirmation of its decision within two working days of providing notification of a decision if the initial notification was not in writing.

(3) **Precertification - residential services (SE only):** For precertification of RTC, TFC and group home, the SE shall make a decision within five (5) working days from receipt of request of services.

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

(5) **Concurrent - routine:**

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

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

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

(6) **Concurrent - urgent:**

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

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

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

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

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

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

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

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

(3) There shall be documentation that relevant clinical information is gathered consistently to support UM decision making. The CLTS MCO/SE UM policies and procedures will clearly define in writing for service providers what constitutes relevant clinical information, as well as how to accurately submit authorization requests.

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

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

(1) The CLTS MCO/SE shall require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease, such as the CLTS MCO/SE medical director.

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

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

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

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

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

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

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

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

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

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

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

K. **HSD access:** HSD or its designee shall have access to the CLTS MCO/SE's UM review documentation on request.

[8.307.8.13 NMAC - N, 8-1-08]

8.307.8.14 STANDARDS FOR CREDENTIALING AND RECREDENTIALING: The CLTS MCO/SE shall document the mechanism for credentialing and recredentialing of service providers with whom it contracts or employs to treat members outside the in-patient setting and who fall under its scope of authority and action. This documentation shall include, but not be limited to, defining the scope of service providers covered, the criteria and the primary source verification of information used to meet the criteria, the process used to make decisions that may not be discriminatory, and the extent of delegated credentialing or recredentialing arrangements. The credentialing process shall be completed within 180 days from receipt of completed application with all required documentation unless there are extenuating circumstances. For providers that do not require credentialing, e.g., environmental modification providers, the CLTS MCO will document that these providers are licensed to do business in New Mexico.

A. **Service provider participation:** The CLTS MCO/SE shall have a process for receiving input from participating service providers regarding credentialing and recredentialing of service providers.

B. **Primary source verification:** At the time of credentialing the service provider, the CLTS MCO/SE shall verify the following information from primary sources:

(1) a current valid license to practice;

(2) the status of clinical privileges at the institution designated by the service provider as the primary admitting facility, if applicable;

(3) valid drug enforcement agency (DEA) or controlled substance registration (CSR) certificate, if applicable;

(4) education and training of service providers, including graduation from an accredited professional program and the highest training program applicable to the academic or professional degree, discipline and licensure of the service provider;

(5) board certification if the service provider states on the application that the service provider is board certified in a specialty; and

(6) current, adequate malpractice insurance, according to the CLTS MCO/SE's policy and history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the service provider; and

(7) primary source verification shall not be required for work history.

C. **Credentialing application:** The CLTS MCO/SE shall use the HSD-approved credentialing form. The service provider shall complete a credentialing application that includes a statement by the applicant regarding:

(1) ability to perform the essential functions of the positions, with or without accommodation;

(2) lack of present illegal drug use;

(3) history of loss of license and felony convictions;

(4) history of loss or limitation of privileges or disciplinary activity;

(5) sanctions, suspensions or terminations imposed by medicare or medicaid; and

(6) applicant attests to the correctness and completeness of the application.

D. **External source verification:** Before a service provider is credentialed, the CLTS MCO/SE shall receive information on the service provider from the following organizations and shall include the information in the credentialing files:

(1) national practitioner data bank, if applicable to the service provider type;

(2) information about sanctions or limitations on licensure from the following agencies, as applicable:

(a) state board of medical examiners, state osteopathic examining board, federation of state medical boards or the department of professional regulations;

(b) state board of chiropractic examiners or the federation of chiropractic licensing boards;

(c) state board of dental examiners;

(d) state board of podiatric examiners;

(e) state board of nursing;

(f) the appropriate state licensing board for other service provider types, including behavioral health; and

(g) other recognized monitoring organizations appropriate to the service provider's discipline;

(3) sanctions by medicare and medicaid, as applicable.

E. **Evaluation of service provider site and medical records.** At the time of credentialing the CLTS MCO shall perform an initial visit to the offices of potential primary care providers, obstetricians, and gynecologists. The SE shall perform an initial visit to the offices of potential high volume behavioral health care service providers, prior to acceptance and inclusion as participating service providers. The CLTS MCO/SE shall determine its method for identifying high volume behavioral health service providers.

(1) The CLTS MCO/SE shall document a structured review to evaluate the site against the CLTS MCO/SE's organizational standards and those specified by the coordinated long-term services contract.

(2) The CLTS MCO/SE shall document an evaluation of the medical record keeping practices at each site for conformity with the CLTS MCO/SE's organizational standards.

F. **Recredentialing:** The CLTS MCO/SE shall have formalized recredentialing procedures.

(1) The CLTS MCO/SE shall formally recredential its service providers at least every three years. During the recredentialing process the CLTS MCO/SE shall verify the following information from primary sources:

(a) a current valid license to practice;

(b) the status of clinical privileges at the hospital designated by the service provider as the primary admitting facility;

(c) valid DEA or CSR certificate, if applicable;

(d) board certification, if the service provider was due to be recertified or became board certified since last credentialed or recredentialed;

(e) history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the service provider; and

(f) a current, signed attestation statement by the applicant regarding:

(i) ability to perform the essential functions of the position, with or without accommodation;

(ii) lack of current illegal drug use;

(iii) history of loss or limitation of privileges or disciplinary action; and

(iv) current professional malpractice insurance coverage.

(2) There shall be evidence that, before making a recredentialing decision, the CLTS MCO has received information about sanctions or limitations on licensure from the following agencies, if applicable:

(a) the national practitioner data bank;

(b) medicare and medicaid;

(c) state board of medical examiners, state osteopathic examining board, federation of state medical boards or the department of professional regulations;

(d) state board of chiropractic examiners or the federation of chiropractic licensing boards;

(e) state board of dental examiners;

(f) state board of podiatric examiners;

(g) state board of nursing;

(h) the appropriate state licensing board for other service provider types; and

(i) other recognized monitoring

organizations appropriate to the service provider's discipline.

(3) The CLTS MCO/SE shall incorporate data from the following sources in its recredentialing decision-making process for service providers:

(a) member grievances and appeals;

(b) information from quality management and improvement activities; and

(c) medical record reviews conducted under Subsection E of 8.307.8.14 NMAC, *standards for credentialing and recredentialing.*

G. **Imposition of remedies:** The CLTS MCO/SE shall have policies and procedures for altering the conditions of the service provider's participation with the CLTS MCO/SE based on issues of quality of care and service. These policies and procedures shall define the range of actions that the CLTS MCO/SE may take to improve the service provider's performance prior to termination.

(1) The CLTS MCO/SE shall have procedures for reporting to appropriate authorities, including HSD or its designee, serious quality deficiencies that could result in a service provider's suspension or termination.

(2) The CLTS MCO/SE shall have an appeal process by which the CLTS MCO/SE may change the conditions of a service provider's participation based on issues of quality of care and service. The CLTS MCO/SE shall inform service providers of the appeal process in writing.

H. **Assessment of organizational providers:** The CLTS MCO/SE shall have written policies and procedures for the initial and ongoing assessment of organizational providers with whom it intends to contract or which it is contracted. Service providers include, but are not limited to, hospitals, home health agencies, nursing facilities, assisted living facilities, free-standing surgical centers, behavioral, psychiatric and addiction disorder facilities or services, residential treatment centers, clinics, 24-hour programs, behavioral health units of general hospitals and free-standing psychiatric hospitals. At least every three years, the CLTS MCO/SE shall confirm that the service provider is in good standing with state and federal regulatory bodies, including HSD, and has been accredited or certified by the appropriate accrediting body and state certification agency or has met standards of participation required by the CLTS MCO/SE.

(1) The CLTS MCO/SE shall confirm that the service provider has been certified by the appropriate state certification agency, when applicable. Behavioral health organizational providers and services are certified by the following:

(a) DOH is the certification agency for organizational services and providers that require certification, except for child and adolescent behavioral health services; and

(b) CYFD is the certification agency for child and adolescent behavioral health organizational services and providers that require certification.

(2) The CLTS MCO/SE shall confirm that the service provider has been accredited by the appropriate accrediting body or has a detailed written plan that could reasonably be expected to lead to accreditation within a reasonable period of time. Behavioral health organizational providers and services are accredited by the following:

(a) adult behavioral health organizational services or providers are accredited by the council on accreditation of rehabilitation facilities (CARF);

(b) child and adolescent accredited residential treatment centers are accredited by the joint commission on accreditation of healthcare organizations (JCAHO); other child behavioral health organizational services or providers are accredited by the council on accreditation (COA); and

(c) organizational services or providers who serve adults, children and adolescents are accredited by either CARF or COA.

[8.307.8.14 NMAC - N, 8-1-08]

8.307.8.15 MEMBER BILL OF RIGHTS: Under medicaid coordinated long-term services, members have certain rights and responsibilities and the CLTS MCO/SE shall have policies and procedures governing member rights and responsibilities. The following subsections shall be known as the "member bill of rights".

A. **Members' rights:**

(1) Members shall have the right to be treated equitably and with respect and recognition of their dignity and need for privacy.

(2) Members shall have the right to receive health care services in a non-discriminatory fashion.

(3) Members who have a disability shall have the right to receive any information in an alternative format in compliance with the Americans with Disabilities Act.

(4) Members or their legal guardians shall have the right to participate with their service providers in decision making in all aspects of their health services, including the course of treatment development, acceptable treatments and the right to refuse treatment.

(5) Members or their legal guardians shall have the right to informed consent.

(6) Members or their legal guardians shall have the right to choose a surrogate decision-maker to be involved as appropriate, to assist with service decisions.

(7) Members or their legal guardians shall have the right to seek a second opinion from a qualified health care professional within the CLTS MCO/SE network, or the CLTS MCO/SE shall arrange for the member to obtain a second opinion outside the network, at no cost to the member. A second opinion may be requested, when the member or member's legal guardian needs additional information regarding recommended treatment or believes the service provider is not authorizing requested services.

(8) Members or their legal guardians shall have a right to voice grievances about the services provided by the CLTS MCO/SE and to make use of the CLTS MCO/SE's grievance process and the HSD fair hearings process without fear of retaliation.

(9) Members or their legal guardians shall have the right to choose from among the available service providers within the limits of the plan network and its referral and prior authorization requirements.

(10) Members or their legal guardians shall have the right to make their wishes known through advance directives regarding health service decisions consistent with federal and state laws and regulations.

(11) Members or their legal guardians shall have the right to access the member's medical records in accordance with the applicable federal and state laws and regulations.

(12) Members or their legal guardians shall have the right to receive information about: the CLTS MCO/SE, its health care services, how to access those services, and the CLTS MCO/SE network providers.

(13) Members or their legal guardians shall have the right to be free from harassment by the CLTS MCO/SE or its network providers in regard to contractual disputes between the CLTS MCO/SE and providers.

(14) Members have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal or state of New Mexico regulations on the use of restraints and seclusion.

(15) Members or their legal guardians shall have the right to select a CLTS MCO and exercise switch enrollment rights without threats or harassment.

B. **Standards for consumer/participant direction**

(1) Members have direct involvement, control, and choice in assessing his/her own needs and identifying, accessing, and managing services and supports to

meet those needs. When appropriate, families or representatives shall be involved in the process. In consumer/participant direction, the process shall also include a member's active participation in making key service plan and service priority decisions as well as evaluating the quality of the services rendered.

(2) CLTS MCO shall recognize a continuum of different levels of informed decision-making authority, control and autonomy, to the extent desired by the member, at any given point in the course of his/her participation in CLTS. These levels shall range from a member choosing not to direct his/her services and instead deferring to trusted family members or representatives of his/her choosing.

(3) Ensure that a member can move across the continuum of decision-making, depending upon his/her needs and circumstances, and shall support the member in his/her decision regarding the level of consumer/participant direction chosen.

C. **Members' responsibilities:** Members or their legal guardians shall have certain responsibilities that will facilitate the treatment process.

(1) Members or their legal guardians shall have the responsibility to provide, whenever possible, information that the CLTS MCO/SE and service providers need in order to care for them.

(2) Members or their legal guardians shall have the responsibility to understand the member's health problems and to participate in developing mutually agreed upon treatment goals.

(3) Members or their legal guardians shall have the responsibility to follow the plans and instructions for services that they have agreed upon with their service providers or to notify service providers if changes are requested.

(4) Members or their legal guardians shall have the responsibility to keep, reschedule or cancel an appointment rather than to simply not show up.

D. **CLTS MCO/SE responsibilities:**

(1) The CLTS MCO/SE shall provide a member handbook to its members and to potential members who request the handbook. The CLTS MCO/SE shall publish in the member handbook the members' rights and responsibilities from the member bill of rights. CLTS MCO/SE shall honor the provisions set forth in the member bill of rights.

(2) The CLTS MCO/SE shall comply with the grievance resolutions process found in 8.307.12 NMAC, *CLTS MCO/SE Member Grievance System*.

(3) The CLTS MCO/SE shall provide members or legal guardians with updated information within 30 days of a material change in the CLTS MCO/SE provider network, procedures for obtaining benefits, the amount, duration or scope of the benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled, and information on grievance, appeal and fair hearing procedures.

(4) The CLTS MCO/SE shall provide members and legal guardians with access to a toll-free hot line for the CLTS MCO/SE's program for grievance management. The toll-free hot line for grievance management shall include the following features:

(a) does not require a "touch-tone" telephone;

(b) allows communication with members whose primary language is not English or who are hearing impaired; and

(c) is in operation 24 hours per day, seven days per week.

(5) The CLTS MCO/SE shall provide active and participatory education of members or legal guardians that takes into account the cultural, ethnic and linguistic needs of members in order to assure understanding of the health care program, improve access and enhance the quality of service provided.

(6) The CLTS MCO/SE shall protect the confidentiality of member information and records.

(a) The CLTS MCO/SE shall adopt and implement written confidentiality policies and procedures that conform to federal and state laws and regulations.

(b) The CLTS MCO/SE's contracts with service providers shall explicitly state expectations about confidentiality of member information and records.

(c) The CLTS MCO/SE shall afford members or legal guardians the opportunity to approve or deny release by the CLTS MCO/SE of identifiable personal information to a person or agency outside the CLTS MCO/SE, except when release is required by law, state regulation, court order, HSD quality standards, or in the case of behavioral health, the collaborative.

(d) The CLTS MCO/SE shall notify members and legal guardians in a timely manner when information is released in response to a court order.

(e) The CLTS MCO/SE shall have written policies and procedures to maintain confidential information gathered or learned during the investigation or resolution of a complaint, including a member's status as a complainant.

(f) The CLTS MCO/SE shall have written policies and procedures to maintain confidentiality of medical records used in quality review, measurement and improvement activities.

(7) When the CLTS MCO/SE delegates member service activity, the CLTS MCO/SE shall retain responsibility for documenting CLTS MCO/SE oversight of the delegated activity.

(8) Policies regarding consent for treatment shall be disseminated annually to service providers within the CLTS MCO/SE network. The CLTS MCO/SE shall have written policies regarding the requirement for service providers to abide by federal and state law and New Mexico medicaid policies regarding informed consent specific to:

(a) the treatment of minors;

(b) adults who are in the custody of the state;

(c) adults who are the subject of an active protective services case with CYFD;

(d) children and adolescents who fall under the jurisdiction of CYFD; and

(e) individuals who are unable to exercise rational judgment or give informed consent consistent with federal and state laws and New Mexico medicaid regulations.

(9) The CLTS MCO/SE shall have a process to detect, measure and eliminate operational bias or discrimination against members. The CLTS MCO/SE shall ensure that its service providers and their facilities comply with the Americans with Disabilities Act.

(10) The CLTS MCO/SE shall provide a member handbook to its members or potential members who request the handbook, and it shall be accessible via the internet.

(11) The CLTS MCO/SE shall develop and implement policies and procedures to allow members to access behavioral health services without going through the PCP. These policies and procedures must afford timely access to behavioral health services.

(12) The CLTS MCO shall not restrict a member's right to choose a provider of family planning services.

(13) The CLTS MCO/SE's communication with members shall be responsive to the various populations by demonstrating cultural competence in the materials and services provided to members. The CLTS MCO/SE shall provide information to its network providers about culturally relevant services and may provide information about alternative treatment options, e.g., American Indian healing practices if available. Information and materials provided by the CLTS MCO/SE to medicaid members shall be written at a sixth-grade language level and shall be made available in the prevalent population language.

[8.307.8.15 NMAC - N, 8-1-08]

8.307.8.16 STANDARDS FOR PREVENTIVE HEALTH SERVICES:

The CLTS MCO shall follow current national standards for preventive health services including behavioral health preventive services. These standards are derived from several sources, including the U.S. preventive services task force, the centers for disease control and prevention; and the American college of obstetricians and gynecologists. Any preventive health guidelines developed by the CLTS MCO under these standards shall be adopted, reviewed at least every two years, updated when appropriate and disseminated to service provider and member. Unless a member refuses and the refusal is documented, the CLTS MCO shall provide the following preventive health services or screens or document that the services (with the results) were provided by other means. The CLTS MCO shall document medical reasons not to perform these services for an individual member. Member refusal is defined to include refusal to consent to and refusal to access services.

A. **Initial assessment:** The CLTS MCO shall perform an initial assessment of the medicaid member's health service needs within 90 days of the date the member enrolls in the CLTS MCO. For this purpose, a member is considered enrolled at the lock-in date.

B. **Immunizations:** The CLTS MCO shall adopt policies that to the extent possible, ensure that within six months of enrollment, members are immunized according to the type and schedule provided by current recommendations of the state department of health advisory committee on immunizations. The CLTS MCO shall provide the immunizations or verify the member's immunization history by a method acceptable to the health advisory committee.

C. **Screens:** The CLTS MCO shall adopt policies which will ensure that, to the extent possible, within six months of enrollment or within six months of a change in screening standards, asymptomatic members receive at least the following preventive screening services.

(1) *Screening for breast cancer*: Females aged 40-69 years shall be screened every one to two years by mammography alone or by mammography and annual clinical breast examination.

(2) *Screening for cervical cancer*: Female members with a cervix shall receive cytopathology testing starting at the onset of sexual activity, but at least by 21 years of age and every three years thereafter until reaching 65 years of age if prior testing has been consistently normal and the member has been confirmed not to be at high risk. If the member is at high risk, the frequency shall be at least annual.

(3) *Screening for colorectal cancer*: Members aged 50 years and older at normal risk for colorectal cancer shall be screened with annual fecal occult blood testing or sigmoidoscopy or colonoscopy or double contrast barium, at a periodicity determined by the CLTS MCO.

(4) *Blood pressure measurement*: Members over age 18 shall receive a blood pressure measurement at least every two years.

(5) *Serum cholesterol measurement*: Male members aged 35 and older and female members aged 45 and older who are at normal risk for coronary heart disease shall receive serum cholesterol and HDL cholesterol measurement every five years. Adults aged 20 or older with risk factors for heart disease shall have serum cholesterol and HDL cholesterol measurements.

(6) *Screening for obesity*: Members shall receive body weight and height/length measurements with each physical exam.

(7) *Screening for elevated lead levels*: Members aged 9-15 months (ideally at 12 months) shall receive a blood lead measurement at least once.

(8) *Screening for tuberculosis*: Routine tuberculin skin testing shall not be required for all members. The following high-risk persons shall be screened or previous screening noted: persons who immigrated from countries in Asia, Africa, Latin America or the Middle East in the preceding five years; persons who have substantial contact with immigrants from those areas; migrant farm workers; and persons who are alcoholic, homeless or injecting drug users. HIV-infected persons shall be screened annually. Persons whose screening tuberculin test is positive (>10 mm of induration) must be referred to the local public health office in their community of residence for contact investigation.

(9) *Screening for rubella*: All female members of childbearing ages shall be screened for rubella susceptibility by history of vaccination or by serology.

(10) *Screening for chlamydia;* All sexually active female members age 25 or younger shall be screened for chlamydia. All female members over age 25 shall be screened for chlamydia if they inconsistently use barrier conception, have more than one sex partner or have had a sexually transmitted disease in the past.

(11) *Screening for type 2 diabetes*: Individuals with one or more of the following risk factors for diabetes shall be screened. Risk factors include a family history of diabetes (parent or sibling with diabetes); obesity (>20% over desired body weight or BMI >27kg/m2); race/ethnicity (e.g. Hispanic, Native American, African American, Asian-Pacific islander); previously identified impaired fasting glucose or impaired glucose tolerance; hypertension (>140/90 mmHg); HDL cholesterol level <35 mg/dl and triglyceride level >250 mg/dl; history of gestational diabetes mellitus (GDM) or delivery of babies over nine lbs.

(12) *Prenatal screening*: All pregnant members shall be screened for preeclampsia, D(Rh) incompatibility, down syndrome, neural tube defects, hemoglobinopathies, vaginal and rectal group B streptococcal infection and screened and counseled for HIV in accordance with the most current recommendations of the American college of obstetricians and gynecologists.

(13) *Newborn screening*: Newborn members shall be screened for those disorders specified in the state of New Mexico metabolic screen.

(14) *Tot-to-teen health checks*: The CLTS MCO shall operate tot-to-teen mandated early and periodic screening, diagnostic and treatment (EPSDT) services as outlined in 8.320.3 NMAC, *Tot-to-Teen Health Checks*. Within three months of enrollment lock-in, the CLTS MCO shall ensure that eligible members (up to age 21) are current according to the screening schedule (unless more stringent requirements are specified in these standards). The CLTS MCO shall encourage PCPs to assess for age, height and gender appropriate weight during EPSDT screens to detect and treat evidence of weight or obesity issues in children and adolescents.

(15) Members over age 21 must be screened to detect high risk for behavioral health conditions at their first encounter with a PCP after enrollment.

(16) The CLTS MCO shall require PCPs to refer members, whenever clinically appropriate, to behavioral health providers. The CLTS MCO/SE shall assist the member with an appropriate behavioral health referral.

D. **Counseling:** The CLTS MCO shall adopt policies that shall ensure that applicable asymptomatic members are provided counseling on the following topics unless recipient refusal is documented:

(1) prevention of tobacco use;

(2) benefits of physical activity;

(3) benefits of a healthy diet;

(4) prevention of osteoporosis and heart disease in menopausal women citing the advantages and disadvantages of calcium and hormonal supplementation;

(5) prevention of motor vehicle injuries;

(6) prevention of household and recreational injuries;

(7) prevention of dental and periodontal disease;

(8) prevention of HIV infection and other sexually transmitted diseases;

(9) prevention of unintended pregnancies; and

(10) prevention or intervention for obesity or weight issues.

E. **Hot line:** The CLTS MCO/SE shall provide a toll-free clinical telephone hot line function that includes at least the following services and features:

(1) clinical assessment and triage to evaluate the acuity and severity of the member's symptoms and make the clinically appropriate referral; and

(2) prediagnostic and post-treatment health care decision assistance based on symptoms.

F. **Health information line:** The CLTS MCO shall provide a toll-free line that includes at least the following services and features:

(1) general health information on topics appropriate to the various medicaid populations, including those with severe and chronic physical and behavioral health conditions; and

(2) preventive/wellness counseling.

G. **Family planning:** The CLTS MCO must have a family planning policy. This policy must ensure that members of the appropriate age of both sexes who seek family planning services are provided with counseling and treatment, if indicated, as it relates to the following:

(1) methods of contraception; and

(2) HIV and other sexually transmitted diseases and risk reduction practices.

H. **Prenatal care:** The CLTS MCO shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal care consistent with the standards of the American college of obstetrics and gynecology. The program shall include at least the following:

(1) educational outreach to all members of childbearing age;

(2) prompt and easy access to obstetrical services, including an office visit with a service provider within three weeks of having a positive pregnancy test (laboratory or home) unless earlier service is clinically indicated;

(3) risk assessment of all pregnant members to identify high-risk cases for special management;

(4) counseling that strongly advises voluntary testing for HIV;

(5) case management services to address the special needs of members who have a high risk pregnancy especially if risk is due to psychosocial factors such as substance abuse or teen pregnancy;

(6) screening for determination of need for a post-partum home visit; and

(7) coordination with other services in support of good prenatal care, including transportation, other community services and referral to an agency that dispenses baby car seats free or at a reduced price.

[8.307.8.16 NMAC - N, 8-1-08]

8.307.8.17 STANDARDS FOR MEDICAL RECORDS:

A. **Standards and policies:** The CLTS MCO/SE shall require that member medical records be maintained on paper or electronic format. Member medical records shall be maintained timely, and be legible, current, detailed and organized to permit effective and confidential patient service and quality review.

(1) The CLTS MCO/SE shall have medical record confidentiality policies and procedures in compliance with state and federal guidelines and HIPAA.

(2) The CLTS MCO/SE shall have medical record documentation standards that are enforced with its CLTS MCO/SE providers and subcontractors and require that records reflect all aspects of patient care, including ancillary services. The documentation standards shall, at a minimum, require the following:

(a) patient identification information (on each page or electronic file);

(b) personal biographical data (date of birth, sex, race or ethnicity (if available), mailing address, residential address, employer, school, home and work telephone numbers, name and telephone numbers of emergency contacts, marital status, consent forms and guardianship information);

(c) date of data entry and date of encounter;

(d) service provider identification (author of entry);

(e) allergies and adverse reactions to medications;

(f) past medical history for patients seen two or more times;

(g) status of preventive services provided or at least those specified by HSD or its designee, summarized in an auditable form (a single sheet) in the medical record within six months of enrollment;

(h) diagnostic information;

(i) medication history including what has been effective and what has not, and why;

(j) identification of current problems;

(k) history of smoking, alcohol use and substance abuse for members 12 years of age or older;

(l) reports of consultations and referrals;

(m) reports of emergency services, to the extent possible;

(n) advance directive for adults; and

(o) record legibility to at least a peer of the author.

(3) For patients who receive two or more services from a behavioral health provider through the SE within a 12-month period, the documentation standards shall meet medicaid requirements and require that the following items also be included in the medical record in addition to the above:

(a) a mental status evaluation that documents affect, speech, mood, thought content, judgment, insight, concentration, memory and impulse control;

(b) DSM-IV diagnosis consistent with the history, mental status examination or other assessment data;

(c) a treatment plan consistent with diagnosis that has objective and measurable goals and time frames for goal attainment or problem resolution;

(d) documentation of progress toward attainment of the goal; and

(e) preventive services such as relapse prevention and stress management.

(4) The CLTS MCO/SE standards for a member's medical record shall include the following minimum detail for individual clinical encounters:

(a) history (and physical examination) for presenting complaints containing relevant psychological and social conditions affecting the patient's behavioral health, including mental health (psychiatric) and substance abuse status;

(b) plan of treatment;

(c) diagnostic tests and the results;

(d) drugs prescribed, including the strength, amount, directions for use and refills;

(e) therapies and other prescribed regimens and the results;

(f) follow-up plans and directions (such as, time for return visit, symptoms that shall prompt a return visit);

(g) consultations and referrals and the results; and

(h) any other significant aspect of the member's physical or behavioral health services.

B. **Review of records:** The CLTS MCO/SE shall have a process to systematically review service provider medical records to ensure compliance with the medical record standards. The CLTS MCO/SE shall institute improvement actions when standards are not met.

(1) The EQRO shall conduct reviews of a representative sample of medical records from the CLTS MCO's primary care providers, obstetricians, and gynecologists.

(2) The CLTS MCO/SE shall have a mechanism to assess the effectiveness of organization-wide and practice-site follow-up plans to increase compliance with the CLTS MCO/SE's established medical record standards and goals.

C. **Access to records:**

The CLTS MCO/SE shall provide HSD or its designee appropriate access to service provider medical records.

(1) The CLTS MCO shall ensure that the PCP maintains a primary medical record for each member, which contains sufficient medical information from all service providers involved in the member's services, to ensure continuity of services. The CLTS MCO shall ensure that service providers involved in the member's services have access to the member's primary medical record, including the SE, when necessary.

(2) The CLTS MCO/SE shall include provisions in its contracts with service providers for appropriate access to the CLTS MCO/SE's members' medical records for purposes of in-state quality reviews conducted by HSD or its designee, and for making medical records available to service providers, including behavioral health, for each clinical encounter.

(3) The CLTS MCO shall have a policy that ensures the confidential transfer of medical and dental information to another primary medical or dental service provider whenever a primary medical or dental provider leaves the CLTS MCO the member changes primary medical or dental service provider or after a member changes enrollment from one CLTS MCO and enrolls in another CLTS MCO.

(4) The SE shall have a policy that ensures the confidential transfer of behavioral health information from one practitioner to another whenever a provider leaves the SE network or whenever the member changes behavioral health provider or practitioner. The SE shall have a policy that ensures the confidential transfer of behavioral health information from one collaborative agency to another.

(5) The CLTS MCO/SE shall forward to HSD or it designee, specific health information from the provider's medical records. Examples of health information will include, but not be limited to, the following:

(a) the member's principal physical and behavioral health problems, as applicable;

(b) the member's current medications, dosage amounts and frequency;

(c) the member's preventive health services history; including behavioral health;

(d) EPSDT screening results (if the member is under age 21); and

(e) other information as requested.

[8.307.8.17 NMAC - N, 8-1-08]

8.307.8.18 STANDARDS FOR ACCESS:

A. **Ensure access:** The CLTS MCO/SE shall establish and follow protocols to ensure the accessibility, availability and referral to service providers for each medically necessary service. The CLTS MCO/SE shall submit documentation to HSD or its designee if requested, at least once per year, giving assurances that it has the capacity to serve the expected enrollment in its service area in accordance with HSD standards and in a format acceptable to HSD. The CLTS MCO/SE shall provide access to the full array of covered services within the benefit package. If a service is unavailable based on the access guidelines, a service equal to or higher than shall be offered.

B. **Access to urgent and emergency services:** Services for emergency conditions provided by physical health providers, including emergency transportation, urgent conditions, and post-stabilization services shall be covered by the CLTS MCO only within the United States for both physical and behavioral health. The SE shall coordinate all behavioral health transportation with the member's respective CLTS MCO. An urgent condition exists when a member manifests acute symptoms and signs that, by reasonable medical judgment, represent a condition of sufficient severity that the absence of medical attention within 24 hours could reasonably result in an emergency condition. Serious impairment of biopsychosocial functioning, imminent out-of-home placement for children and adolescents or serious jeopardy to the behavioral health of the member are considered urgent conditions. An emergency condition exists when a member manifests acute symptoms and signs that, by reasonable lay person judgment, represent a condition of sufficient severity that the absence of immediate medical attention, including behavioral health, could reasonably result in death, serious impairment of bodily function or major organ or serious jeopardy to the overall health of the member. Post-stabilization services means covered services related to an emergency medical or behavioral health condition, that are provided after the member is stabilized in order to maintain the stabilized condition and may include improving or resolving the member's condition.

(1) The CLTS MCO/SE shall ensure that there is no clinically significant delay caused by the CLTS MCO/SE's utilization control measures. Prior authorization is not required for emergency services in or out of the CLTS MCO/SE network, and all emergency services shall be reimbursed at the medicaid fee-for-service rate. The CLTS MCO/SE shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical or behavioral health condition under the prudent lay person standard, turned out to be non-emergency in nature.

(2) The CLTS MCO/SE shall ensure that the member has the right to use any hospital or other licensed emergency setting for emergency services, regardless of whether the service provider is contracted with the CLTS MCO/SE.

(3) The CLTS MCO/SE shall ensure that members have access to the nearest appropriately designated trauma center according to established EMS triage and transportation protocols.

C. **Primary care provider availability:** The CLTS MCO shall follow a process that ensures a sufficient number of primary care providers are available to members to allow the members a reasonable choice among providers.

(1) The CLTS MCO shall have at least one primary care provider available per 1,500 members and no more than 1,500 members assigned to a single provider unless approved by HSD or its designee.

(2) The minimum number of primary care providers from which to choose and the distances to those providers shall vary by county based on whether the county is urban, rural or frontier. Urban counties are: Bernalillo, Los Alamos, Santa Fe and Dona Ana. Frontier counties are: Catron, Harding, DeBaca, Union, Guadalupe, Hidalgo, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, San Miguel and Cibola. Rural counties are those that are not urban or frontier. The standards are as follows:

(a) 90 percent of urban residents shall travel no farther than 30 miles;

(b) 90 percent of rural residents shall travel no farther than 45 miles; and

(c) 90 percent of frontier residents shall travel no farther than 60 miles.

D. **Pharmacy provider availability:** The CLTS MCO/SE shall ensure that a sufficient number of pharmacy providers are available to members. The CLTS MCO/SE shall ensure that pharmacy services meet geographic access standards based on the member's county of residence. The access standards are as follows:

(1) 90 percent of urban residents shall travel no farther than 30 miles;

(2) 90 percent of rural residents shall travel no farther than 45 miles; and

(3) 90 percent of frontier residents shall travel no farther than 60 miles.

E. **Access to health care services:** The CLTS MCO shall ensure that there are a sufficient number of PCPs and dentists available to members to allow members a reasonable choice. The SE shall ensure that there are a sufficient number of behavioral health providers, based on the least restrictive, medically necessary needs of its members, available statewide to members to allow members a reasonable choice.

(1) The CLTS MCO shall report

to HSD or its designee all service provider groups, health centers and individual physician practices and sites in their network that are not accepting new medicaid members.

(2) CLTS MCO only: For routine, asymptomatic, member-initiated, outpatient appointments for primary medical services, the request-to-appointment time shall be no more than 30 days, unless the member requests a later time.

(3) CLTS MCO only: For routine asymptomatic member-initiated dental appointments, the request to appointment time shall be consistent with community norms for dental appointments.

(4) CLTS MCO only: For routine, symptomatic, member-initiated, outpatient appointments for nonurgent primary medical and dental services, the request-to-appointment time shall be no more than 14 days, unless the member requests a later time.

(5) SE only: For non urgent behavioral health care, the request-to-appointment time shall be no more than 14 days, unless the member requests a later time.

(6) CLTS MCO/SE: Primary medical, dental and behavioral health service outpatient appointments for urgent conditions shall be available within 24 hours.

(7) CLTS MCO only: For specialty outpatient referral and consultation appointments, excluding behavioral health, which is addressed in (5) above, the request-to-appointment time shall generally be consistent with the clinical urgency, but no more than 21 days, unless the member requests a later time.

(8) CLTS MCO only: For routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, the request-to-appointment time shall be consistent with the clinical urgency, but no more than 14 days, unless the member requests a later time.

(9) CLTS MCO only: For outpatient diagnostic laboratory, diagnostic imaging and other testing, if a "walk-in" rather than an appointment system is used, the member wait time shall be consistent with severity of the clinical need.

(10) CLTS MCO only: For urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability shall be consistent with the clinical urgency, but no longer than 48 hours.

(11) CLTS MCO/SE: The in-person prescription fill time (ready for pickup) shall be no longer than 40 minutes. A prescription phoned in by a service provider shall be filled within 90 minutes.

(12) CLTS MCO/SE: The timing of scheduled follow-up outpatient visits with service providers shall be consistent with the clinical need.

(13) The CLTS MCO/SE shall ensure that a medically necessary pharmaceutical agent is provided in a clinically timely manner.

(14) The CLTS MCO/SE's preferred drug list (PDL) shall follow HSD guidelines in Subsection O of 8.307.7.11 NMAC, *services included in the salud! benefit package*, *pharmacy services*.

(15) The CLTS MCO shall approve or deny a request for new durable medical equipment (DME) or for repairs to existing DME owned or rented by the member within seven working days of the request date.

(a) All new customized or made-to-measure DME or customized modifications to existing DME owned or rented by the member shall be delivered to the member within 150 days of the request date.

(b) All standard DME shall be delivered within 24 hours of the request, if needed on an urgent basis.

(c) All standard DME not needed on an urgent basis shall be delivered within a time frame consistent with clinical need.

(d) All DME repairs or non-customized modifications shall be delivered within 60 days of the request date.

(e) The CLTS MCO shall have an emergency response plan for non-customized DME needed on an emergent basis.

(16) The CLTS MCO shall approve or deny a request for prescribed medical supplies within seven working days of the request date. The CLTS MCO shall ensure that:

(a) members can access prescribed medical supplies within 24 hours when needed on an urgent basis;

(b) members can access routine medical supplies within a time frame consistent with the clinical need;

(c) subject to any requirements to procure a physician's order to provide supplies to the member, members utilizing medical supplies on an ongoing basis shall submit to the CLTS MCO lists of needed supplies monthly; and the CLTS MCO or its subcontractor shall contact the member if the requested supplies cannot be delivered in the time frame expected and make other delivery arrangements consistent with clinical need.

(17) The CLTS MCO shall ensure that members and members' families receive proper instruction on the use of DME and medical supplies provided by the CLTS MCO/SE or its subcontractor.

F. **Access to transportation services:** The CLTS MCO shall provide the transportation benefit for medically necessary physical and behavioral health. The CLTS MCO shall coordinate behavioral health transportation services with the SE, and the SE shall coordinate transportation services with the member's respective CLTS MCO. The CLTS MCO shall have sufficient transportation service providers available to meet the needs of members, including an appropriate number of handivans available for members who are wheelchair or ventilator dependant or have other equipment needs. The CLTS MCO shall develop and implement policies and procedures to ensure that:

(1) transportation arranged is appropriate for the member's clinical condition;

(2) the history of services is available at the time services are requested to expedite appropriate arrangements;

(3) CPR-certified drivers are available to transport members consistent with clinical need;

(4) the transportation type is clinically appropriate, including access to non-emergency ground ambulance carriers;

(5) members can access and receive authorization for medically necessary transportation services under certain unusual circumstances without advance notification; and

(6) minors are accompanied by a parent or legal guardian as indicated to provide safe transportation.

G. **Use of technology:** The CLTS MCO/SE is encouraged to use state-of-the-art technology, such as telemedicine, to ensure access and availability of services statewide.

[8.307.8.18 NMAC - N, 8-1-08]

8.307.8.19 DELEGATION: Delegation is a process whereby a CLTS MCO/SE gives another entity the authority to perform certain functions on its behalf. The CLTS MCO/SE is fully accountable for all predelegation and delegation activities and decisions made. The CLTS MCO/SE shall document its oversight of the delegated activity. The SE may assign, transfer, or delegate to a subcontractor key management functions including, but not limited to, care coordination and universal credentialing with the explicit written approval of HSD and the collaborative.

A. A mutually agreed upon document between CLTS MCO/SE and the delegated entity shall describe:

(1) the responsibilities of the CLTS MCO/SE and the entity to which the activity is delegated;

(2) the delegated activity;

(3) the frequency and method of reporting to the CLTS MCO/SE;

(4) the process by which the CLTS MCO/SE evaluates the delegated entity's performance; and

(5) the remedies up to, and including, revocation of the delegation, available to the CLTS MCO/SE if the dele-

gated entity does not fulfill its obligations.

B. The CLTS MCO/SE shall document evidence that the CLTS MCO/SE:

(1) evaluated the delegated entity's capacity to perform the delegated activities prior to delegation;

(2) evaluates regular reports and proactively identifies opportunities for improvement; and

(3) evaluates at least semi-annually the delegated entity's activities in accordance with the CLTS MCO/SE's expectations and HSD's standards.

[8.307.8.19 NMAC - N, 8-1-08]

HISTORY OF 8.307.8 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG TERM SERVICES
PART 9 COORDINATION OF SERVICES

8.307.9.1 ISSUING AGENCY: Human Services Department
[8.307.9.1 NMAC - N, 8-1-08]

8.307.9.2 SCOPE: This rule applies to the general public.
[8.307.9.2 NMAC - N, 8-1-08]

8.307.9.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.307.9.3 NMAC - N, 8-1-08]

8.307.9.4 DURATION: Permanent
[8.307.9.4 NMAC - N, 8-1-08]

8.307.9.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.9.5 NMAC - N, 8-1-08]

8.307.9.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.9.6 NMAC - N, 8-1-08]

8.307.9.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.9.7 NMAC - N, 8-1-08]

8.307.9.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.9.8 NMAC - N, 8-1-08]

8.307.9.9 COORDINATION OF SERVICES:

A. The CLTS MCO/SE shall develop and implement policies and procedures to ensure access to service coordination for individuals with special health care needs (ISHCN), as set forth in 8.307.15.9 NMAC, *services for individuals with special health care needs*. Service coordination is defined as a service to assist members with special health care needs, on an as needed basis. It is person-centered, family-focused when appropriate, culturally competent, and strengths-based. Service coordination can help to ensure that the physical and behavioral health needs of the medicaid population are identified and that services are provided and coordinated with all service providers, individual members and the family, if appropriate, and authorized by the member. Service coordination operates within the CLTS MCO/SE with a dedicated service coordination staff functioning independently, but is structurally linked to the other CLTS MCO/SE systems, such as quality assurance, member services and grievances. Service coordination is not "gate keeping" or "utilization management". Clinical decisions shall be based on medically necessary covered services and not fiscal considerations. If both physical and behavioral health conditions exist, the primary care coordination responsibility lies with the condition that is most acute. Services shall be coordinated between both CLTS MCO staff and behavioral health staff of the statewide entity (SE). The entity (CLTS MCO or SE) responsible for the care of the most acute condition shall be the primary lead on service coordination activities, with necessary assistance and collaboration from other entities. The CLTS MCO/SE shall conduct the following system processes for service coordination:

(1) identify proactively the eligible populations;

(2) identify proactively the needs of the eligible population;

(3) provide a designated person to be primarily responsible for coordinating the health services furnished to a specific member and to serve as the single point of contact for the member; and

(4) ensure access to service coordination for all medicaid eligible ISHCN, as required by federal regulations.

B. **General service coordination requirements:**

(1) CLTS MCO/SE provide statewide service coordination by licensed or otherwise qualified professionals for members with multiple and complex special health care needs. Service coordinators can be licensed registered nurses (RNs), licensed practical nurses (LPNs), licensed social workers, or have a bachelor's degree from an accredited college or university in nursing, social work, counseling, special education, or a closely related field and have a minimum of one year's experience in working with disabled and elderly individuals. This requirement may be waived by the state if the CLTS MCO demonstrates that no persons with these qualifications are available in a specified service area. In this circumstance, the CLTS MCO may, with state approval, provide a service coordinator with alternative credentials.

(2) CLTS MCO only empower members and their family or caregivers to make informed service coordination decisions based on their individualized service plan (ISP) priorities.

(3) CLTS MCO only provide support for transition and community reintegration or the least restrictive environment based on the member's ISP goals.

(4) CLTS MCO only, ensure that service coordinators are meeting face-to-face or telephonically with those individuals receiving long-term support services as frequently as appropriate to support the member's goals and to foster independence. Face-to-face meetings shall occur at least once quarterly and telephone contacts shall occur at least monthly for the 1915 (c) waiver participants.

(5) CLTS MCO/SE develop and implement written policies and procedures approved by the state, which govern how members with multiple or complex special health care needs shall be identified.

(6) CLTS MCO/SE develop and implement written policies and procedures governing how service coordination shall be provided for members with special health care needs, as required by federal regulation. The CLTS MCO policies shall address the development of the member's ISP, based on a comprehensive assessment of the goals, capacities, and member's condition and the needs and goals of the family. Also included shall be the criteria for evaluating a member's response to services and revising the ISP when indicated. The member or the member's representative shall be involved in the development of the ISP, as appropriate. The member shall have the right to refuse service coordination.

(7) CLTS MCO only adhere to clear expectations and requirements related to ISHCN that may include, but are not limited to: direct access to specialists, as needed; relevant coordinated long-term services specialty providers; relevant emergency resource requirements; relevant rehabilita-

tion therapy services to maintain functionality; relevant clinical practice guidelines for provision of care and services; and relevant utilization management for services.

(8) CLTS MCO only develop and implement written policies and procedures that ensure that health and social service delivery is coordinated across service providers, service systems, and varied levels of care to maximize the member's ISP goals and outcomes.

(9) CLTS MCO only develop and implement written policies and procedures that ensure that all transitions of service from institutional to community-based services are proactively coordinated with all service providers involved in the member's ISP.

(10) CLTS MCO only develop and implement written policies and procedures that ensure that comprehensive service delivery, across varied funding sources, such as medicare and medicaid for dually eligible members, is seamless to the member.

(11) CLTS MCO/SE measure and evaluate outcomes and monitor progress of members to ensure that covered services are received, and assist in resolution of identified problems that prevent duplication of covered services.

(12) CLTS MCO only specify how service coordination shall be supported by an internal information system.

(13) CLTS MCO only develop and implement written policies and procedures to establish a working relationship between service coordinators, network providers, members, and caregivers.

(14) CLTS MCO/SE continue to work with school-based providers to identify and coordinate with the child or adolescent's primary care provider (PCP).

C. The service coordinator shall be responsible for the following activities:

(1) CLTS MCO/SE communicating to the member the service coordinator's name and how to contact this person;

(2) CLTS MCO/SE ensuring and coordinate access to a qualified service provider who is responsible for developing and implementing a comprehensive treatment plan as per applicable provider regulations;

(3) CLTS MCO/SE ensuring appropriate coordination between physical and behavioral health services and non-coordinated long-term services; In the case of the SE, also coordinate care among other applicable agencies and the collaborative;

(4) CLTS MCO only coordinating the needs and identify the status of co-managed cases with the SE behavioral health service coordinator;

(5) CLTS MCO/SE monitoring progress of members to ensure that medically necessary services are received, to assist in resolving identified problems, and to prevent duplication of services;

(6) SE only coordinate the provision of necessary services and actively assist members in obtaining such services when a local community case manager is not available;

(7) SE only develop a member's individual plan of care (care coordination plan) with involvement from the member and family/guardian (as appropriate) based on a comprehensive assessment of the goals, capabilities and the behavioral health service needs of the member and with consideration of the needs and goals of the family (if appropriate); provide for an evaluation process of the plan that measures the member's response to care and ensures revision of the plan as needed;

(8) CLTS MCO only ensuring the development of a member's individual plan of service, based on a comprehensive assessment of the goals, capabilities and medical condition of the member and with consideration of the needs and goals of the family; provide for an evaluation process that measures the member's response to services and ensures revision of the plan as needed;

(9) CLTS MCO/SE involving the member and family in the development of the plan of services, as appropriate; a member or family shall have the right to refuse service coordination or case management, that will be documented in the service coordination file; and

(10) CLTS MCO/SE ensuring that all necessary information is shared with key service providers with the member's written permission or documented verbal permission; this information sharing is required to ensure optimum services and communication between primary care and behavioral health care, as well as among involved behavioral health service providers and across other service providing systems.

D. Standards for individual service plan development (ISP):

(1) treatment and service plans may be documented using a form submitted by the CLTS MCO approved by the state;

(2) have and comply with written policies and procedures for the development of the ISP, including ensuring that: the member is involved and in control, to the extent possible and desired by the member in development of the ISP; individuals whom the member wishes to participate in the planning process are included in the planning process; the member's needs are assessed and services and goods are identified to meet those needs; the member's desired level of direct management is agreed upon; and responsibilities for implementation of the ISP are identified;

(3) educate each member (or family or legal representatives, as indicated) about the person-centered planning process, the range of covered services; and, depending on the member's desired level of self-management, any additional information to assist the member during development of the ISP; and

(4) upon completion of a comprehensive assessment, according to parameters identified in the CLTS MCO contract, the CLTS MCO shall:

(a) begin the ISP development process; the member shall be the center of the planning process, in collaboration with the CLTS MCO service coordinator and other individuals of the member's planning team; the planning team shall be composed according to criteria identified in the CLTS MCO contract;

(b) convene the planning team to develop and implement the ISP in accordance with contract requirements; the CLTS MCO service coordinator will inform and educate the member (or his/her family, legal guardian, or representative, as indicated) about waiver services and other resources available to meet the member's needs;

(c) ensure that the member (or his/her family, legal guardian, or representative, as indicated), in collaboration with his/her planning team, identifies preferred outcomes for services, goals, and the supports necessary to reach the member's desired goals and outcomes; risks associated with the outcomes, and methods to mitigate those risks shall be identified, while acknowledging and promoting the member's independence;

(d) list specific interventions in the ISP for implementing each goal including measurable objectives, services, supports, timelines, and assignments for individuals who are responsible for implementation, and methods of measuring and evaluating outcomes of the ISP; the ISP shall address all services provided to the member, including through CLTS, medicare, community resources, natural supports, and other resources; and

(e) review and update the ISP annually, or more frequently, if needed, or when the member or caregiver requests; the member is at risk of significant harm; the member experiences a significant medical event or change in condition/functioning, e.g., hospitalization, frequent falls, serious accident or illness; the member experiences a significant change in social supports or environment, e.g., caretaker becomes ill, home is damaged; or the member has been referred to adult protective services because of abuse, neglect, or exploitation.

E. For clarification purposes, activities provided through service

coordination at the CLTS MCO/SE level differ from case management activities provided as part of the targeted case management programs included in the medicaid benefit package. These external case management programs shall continue to be important service components delivered as a portion of the medicaid benefit package. The case management programs are defined in 8.326.2 NMAC through 8.326.6 NMAC and 8.320.5 NMAC.
[8.307.9.9 NMAC - N, 8-1-08]

8.307.9.10 COORDINATION OF PHYSICAL AND BEHAVIORAL HEALTH SERVICES BENEFITS:

A. **Coordination of physical and behavioral health services:** Physical and behavioral health services shall be provided through a clinically coordinated system between the CLTS MCO and SE. The CLTS MCO and SE shall coordinate a member's services with one another, if the member has both physical and behavioral health needs. Both physical and behavioral service providers would benefit from having access to relevant medical records of mutually-served members to ensure the maximum benefit of services to the member. The CLTS MCO and the SE shall develop and share policies and procedures to ensure effective service coordination across systems as authorized by the member. The CLTS MCO/SE shall have defined processes for coordinating complex physical and behavioral health cases, which include participation of its medical directors. Confidentiality and HIPAA regulations apply during this coordination process.

B. **Coordination mechanisms:** The CLTS MCO/SE shall work proactively to achieve appropriate coordination between physical and behavioral health services by implementing complimentary policies and procedures for the coordination of services. The CLTS MCO/SE shall implement policies and procedures that maximize service coordination to access medicaid services external to the MCO's program, such as home and community-based waiver programs, the medicaid school-based services (MSBS) program and the children's medical services (CMS). The CLTS MCO/SE shall have procedures that ensure PCPs consistently receive communication, with the member's written consent, regarding member status and follow-up care by a specialist provider. The CLTS MCO/SE shall provide comprehensive education to its provider networks regarding HIPAA compliant protocols for sharing information between physical health, behavioral health and other providers.

C. **Referrals for behavioral health services:** The CLTS MCO shall educate and assist the PCPs regarding proper procedures for making appropriate referrals for behavioral health consultation and treatment through the SE.

D. **Referrals for physical health services:** The SE shall educate and assist the behavioral health providers regarding proper procedures for making appropriate referral for physical health consultation and treatment when accessing needed physical health services. The SE shall coordinate care with primary care providers, with the written consent.

E. **Referral policies and procedures:** The CLTS MCO/SE shall offer statewide trainings to all service providers regarding its specific referral policies and procedures. The CLTS MCO/SE referral policies and procedures shall also be provided in provider manuals distributed to all contracted service providers. The CLTS MCO/SE shall develop and implement policies and procedures that encourage PCPs to refer members to the SE for behavioral health services or directly to behavioral health service providers in an appropriate and timely manner, with the member's documented permission. A member may access behavioral health services through direct contact with the SE or by going directly to a behavioral health provider. A written report of the behavioral health service containing sufficient information to coordinate the member's care shall be forwarded to the PCP by the behavioral health provider with the member's written consent with oversight from the SE within seven calendar days after screen and evaluation. The CLTS MCO shall ensure that its policies and procedures for service coordination ensure that referrals to other specialists, non-network providers, and all publicly supported providers for medically necessary and home and community-based covered services are available to members, if such services are not reasonably available in the CLTS MCO network. The CLTS MCO policy for non-network providers shall require the CLTS MCO to coordinate with the non-network provider with regard to payment unless otherwise agreed to by the CLTS MCO and HSD or its designee.

F. **Indicators for PCP referral to behavioral health services:** The following are common indicators for a referral to the SE for behavioral health services or for a referral directly to a behavioral health provider by a PCP:

(1) suicidal/homicidal ideation or behavior;

(2) at-risk of hospitalization due to a behavioral health condition;

(3) children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital, residential treatment facility, or treatment foster care placement;

(4) trauma victims including possible abused or neglected members;

(5) serious threat of physical or sexual abuse or risk to life or health due to impaired mental status and judgment, mental retardation, or other developmental disabilities;

(6) request by member, parent or legal guardian of a minor for behavioral health services;

(7) clinical status that suggests the need for behavioral health services;

(8) identified psychosocial stressors and precipitants;

(9) treatment compliance complicated by behavioral characteristics;

(10) behavioral, psychiatric or substance abuse factors influencing a medical condition;

(11) victims or perpetrators of abuse and neglect;

(12) non-medical management of substance abuse;

(13) follow-up to medical detoxification;

(14) an initial PCP contact or routine physical examination indicates a substance abuse or mental health problem;

(15) a prenatal visit indicates a substance abuse or mental health problem;

(16) positive response to questions indicates substance abuse, observation of clinical indicators or laboratory values that indicate substance abuse;

(17) a pattern of inappropriate use of medical, surgical, trauma, urgent care or emergency room services that could be related to substance abuse or other behavioral health conditions; and

(18) the persistence of serious functional impairment.

G. **Referrals for physical health or behavioral health consultation and treatment:** The CLTS MCO shall educate and assist physical health providers to make appropriate referrals for behavioral health consultation and treatment. The SE shall educate and assist behavioral health providers to make appropriate referrals for physical health consultation and treatment to the medicaid member's PCP or CLTS MCO as authorized by the member.

H. **Independent access:** The CLTS MCO/SE shall develop and implement policies and procedures that allow member's access to behavioral health services through the SE directly and without referral from the PCP. These policies and procedures shall require timely access to behavioral health services.

I. **Behavioral health plan:** The behavioral health provider designated as the "clinical home" shall take responsibility for developing and implementing the member's behavioral health treatment plan in coordination with the member, parent or legal guardian and other

service providers, when clinically indicated. With the member's documented permission, multiple behavioral health providers shall coordinate their treatment plans and progress information to provide optimum service for the member. Community case managers shall be responsible for monitoring the treatment plan and coordinating treatment team meetings for members receiving behavioral health services from multiple service providers.

J. **On-going reporting:**

(1) The CLTS MCO shall require that a PCP must keep the member's behavioral health provider informed, with the member's written consent, of the following:

(a) drug therapy;

(b) laboratory and radiology results;

(c) medical consultations; and

(d) sentinel events such as hospitalization and emergencies.

(2) The SE shall require that a behavioral health provider must keep the member's PCP informed, with the member's written consent, of the following;

(a) drug therapy;

(b) laboratory and radiology results;

(c) sentinel events such as hospitalization, emergencies and incarceration;

(d) discharge from a psychiatric hospital, residential treatment services, treatment foster care placement, or from other behavioral health services; and

(e) all transitions in level of care

K. **Psychiatric consultation:** The PCP and all behavioral health providers are encouraged to obtain consultations and assistance with psychopharmacotherapy and diagnostic evaluations from an SE contracted psychiatrist or other behavioral health specialist with prescribing authority, when clinically appropriate.

[8.307.9.10 NMAC - N, 8-1-08]

8.307.9.11 COORDINATION WITH WAIVER PROGRAMS: The CLTS MCO/SE shall have policies and procedures governing coordination of services with home and community-based medicaid waiver programs to assist with complex service coordination. The CLTS MCO/SE shall coordinate services with the member's waiver case manager to ensure that medical information is shared, following HIPAA guidelines, and that medically necessary services are provided and are not duplicated. HSD or its designee shall monitor utilization of services by waiver recipients to ensure that the CLTS MCO/SE provides to members who are waiver participants all benefits included in the medicaid benefit package.

[8.307.9.11 NMAC - N, 8-1-08]

8.307.9.12 COORDINATION OF SERVICES WITH CHILDREN, YOUTH AND FAMILIES DEPARTMENT (CYFD) AND AGING AND LONG TERM SERVICES DEPARTMENT (ALTSD): The CLTS MCO/SE shall have policies and procedures governing coordination of services with the CYFD protective services division (PSD) and juvenile justice division (JJD). If the member is receiving case management services through CYFD, the primary responsibility for the case management function remains with CYFD, and the CLTS MCO/SE shall assist with service coordination. If child protective services (CPS) or juvenile justice division (JJD) has an open case on a member, the CYFD social worker assigned to the case shall be involved in the assessment and treatment plan, including decisions regarding the provision of services for the member. The CLTS MCO/SE shall have policies and procedures governing coordination of services with ALTSD's adult protective services. The CLTS MCO/SE shall ensure that any APS worker actively involved in an individual's life is included in service coordination. The CLTS MCO/SE shall assist CYFD and ALTSD staff in identifying access to all medically necessary services identified in the service coordination plan. The CLTS MCO/SE shall designate a single contact point within the CLTS MCO/SE for service coordination purposes.

A. **Children's code compliance:** The CLTS MCO/SE policies and procedures shall comply with the current New Mexico Children's Code.

B. **Adult Protective Services Act compliance:** The CLTS MCO/SE's policies and procedures shall comply with New Mexico Statutes, Chapter 27, Section 7 (27-7-14 through 27-7-31), the "Adult Protective Services Act."

[8.307.9.12 NMAC - N, 8-1-08]

8.307.9.13 COORDINATION OF SERVICES WITH SCHOOLS: The CLTS MCO/SE shall implement policies and procedures regarding coordination with the public schools for members receiving medicaid services excluded from coordinated long-term services, as specified by an individual education plan (IEP) or individualized family service plan (IFSP). If the member receives case management through the IEP or IFSP, the primary responsibility for the case management function remains with the school, and the CLTS MCO/SE shall assist with service coordination. Coordination between the schools and the CLTS MCO/SE shall ensure that members receive medically necessary services that complement the IEP or IFSP services and promote the highest level of function for the child. The CLTS MCO/SE shall be responsible for implementing policies and procedures for coordination of services for children returning to school after extended absences, which may be due to inpatient, residential treatment services or treatment foster care placement.

[8.307.9.13 NMAC - N, 8-1-08]

HISTORY OF 8.307.9 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG TERM SERVICES
PART 10 ENCOUNTERS

8.307.10.1 ISSUING AGENCY: Human Services Department

[8.307.10.1 NMAC - N, 8-1-08]

8.307.10.2 SCOPE: This rule applies to the general public.

[8.307.10.2 NMAC - N, 8-1-08]

8.307.10.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute See NMSA 1978 Section 27-2-12 et. seq.

[8.307.10.3 NMAC - N, 8-1-08]

8.307.10.4 DURATION: Permanent

[8.307.10.4 NMAC - N, 8-1-08]

8.307.10.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.

[8.307.10.5 NMAC - N, 8-1-08]

8.307.10.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.

[8.307.10.6 NMAC - N, 8-1-08]

8.307.10.7 DEFINITIONS: See 8.307.1.7 NMAC.

[8.307.10.7 NMAC - N, 8-1-08]

8.307.10.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.

[8.307.10.8 NMAC - N, 8-1-08]

8.307.10.9 ENCOUNTERS: The

coordinated long-term services managed care organization (CLTS MCO) and single statewide entity (SE) shall submit encounter data to the human services department (HSD) under requirements established by HSD or its designee. The centers for medicare and medicaid services (CMS) require that encounter data be used for rate-setting purposes and for reporting cost neutrality for services rendered under the section 1915(c) waiver. HSD maintains oversight responsibility for evaluating and monitoring the volume, timeliness and quality of encounter data submitted by the CLTS MCO/SE. If a CLTS MCO/SE contracts with a third party to process and submit encounter data, the CLTS MCO/SE remains responsible for the quality, accuracy and timeliness of the encounter data submitted to HSD. HSD or its designee shall communicate directly with the CLTS MCO/SE, not with the third party contractor, regarding requirements, deficiencies, quality, accuracy and timeliness of encounter data. CLTS MCO/SE encounter data shall be used to determine compliance with performance measures and other contractual requirements, as appropriate.
[8.307.10.9 NMAC - N, 8-1-08]

8.307.10.10 ENCOUNTER SUBMISSION MEDIA: Encounter data shall be submitted to HSD or its designee on electronic media, as designated and directed by HSD.
[8.307.10.10 NMAC - N, 8-1-08]

8.307.10.11 ENCOUNTER SUBMISSION TIMEFRAMES: The CLTS MCO/SE shall submit encounter data to HSD within 120 days of the service delivery date or discharge. HSD or its designee shall establish error thresholds, time frames and procedures for the submission, correction and resubmission of encounter data.
[8.307.10.11 NMAC - N, 8-1-08]

8.307.10.12 ENCOUNTER DATA ELEMENTS: Encounter data elements are a combination of those elements required by Health Insurance Portability and Accountability Act of 1996 (HIPAA) -compliant transaction formats, which comprise a minimum core data set for states and the CLTS MCO/SE, and those required by CMS, HSD or the collaborative for use in the coordinated long-term services program. Encounter data elements are specified in the medicaid systems manual. HSD or its designee may increase or reduce or make mandatory or optional, data elements as it deems necessary.
[8.307.10.12 NMAC - N, 8-1-08]

HISTORY OF 8.307.10 NMAC:
[RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG TERM SERVICES
PART 11 REIMBURSEMENT

8.307.11.1 ISSUING AGENCY: Human Services Department
[8.307.11.1 NMAC - N, 8-1-08]

8.307.11.2 SCOPE: This rule applies to the general public.
[8.307.11.2 NMAC - N, 8-1-08]

8.307.11.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 27-2-12 et. seq.
[8.307.11.3 NMAC - N, 8-1-08]

8.307.11.4 DURATION: Permanent
[8.307.11.4 NMAC - N, 8-1-08]

8.307.11.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.11.5 NMAC - N, 8-1-08]

8.307.11.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.11.6 NMAC - N, 8-1-08]

8.307.11.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.11.7 NMAC - N, 8-1-08]

8.307.11.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.11.8 NMAC - N, 8-1-08]

8.307.11.9 REIMBURSEMENT FOR COORDINATED LONG-TERM SERVICES:

A. **Payment for services:** The human services department (HSD) shall make actuarially sound payments under capitated risk contracts to the designated coordinated long-term services managed care organizations (CLTS MCOs) and single statewide entity (SE). Rates, whether set by HSD or negotiated between HSD and the CLTS MCO/SE, are considered confidential. Rates shall be appropriate for the medicaid populations to be covered and the services to be furnished under the contract. The CLTS MCO/SE shall be responsible for the provision of services to members during the month of capitation. Medicaid members shall not be liable for debts incurred by a CLTS MCO/SE under the CLTS MCO's/SE's contract for providing health services to medicaid members. This shall include, but not be limited to:

(1) the CLTS MCO's/SE's debts in the event of its insolvency;

(2) services provided to the member that are not included in the medicaid benefit package and for which HSD does not pay the CLTS MCO/SE, e.g. value added services;

(3) when the CLTS MCO/SE does not pay the service provider that furnishes the services under contractual, referral, or other arrangement;

(4) payments for covered services furnished under contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the CLTS MCO/SE provided the service directly; and

(5) if a CLTS MCO/SE member loses eligibility for any reason and is reinstated as eligible by HSD before the end of the month, the CLTS MCO/SE shall accept a retro capitation payment for that month of eligibility and assume financial responsibility for all medically necessary covered benefits and services supplied during that month to the member.

B. **Capitation disbursement requirements:** HSD shall pay a capitated amount to the CLTS MCO/SE for the provision of the coordinated long-term services benefit package at specified rates. The monthly rate is based on actuarially sound capitation rate cells. The CLTS MCO/SE shall accept the capitation rate paid each month by HSD as payment in full for all services to be provided pursuant to the agreement, including all administrative costs associated therewith. HSD or its designee will calculate or verify the CLTS MCO's/SE's income at the end of the state fiscal year to determine if expenditures were made on the services required under the contract utilizing reported information and the department of insurance reports. Administrative costs, to be no higher than the allowable percent, including all CLTS MCO/SE-delegated entities (if applicable), and other financial information will be monitored. The CLTS MCO/SE does not have the option of deleting benefits from the medicaid defined benefit package. Should the CLTS MCO/SE not meet the required administrative or direct services costs within the terms of the contract, sanctions or financial penalties may be imposed.

C. **Payment timeframes:**

Clean claims as defined in Subsection L of 8.307.1.7 NMAC, *definitions*, shall be paid by the CLTS MCO/SE to contracted and noncontracted service providers according to the following timeframe: 90 percent within 30 days of the date of receipt, and 99 percent within 90 days of the date of receipt, as required by federal guidelines in 42 CFR Section 447.45. For claims from day activity providers, assisted living providers and home health agencies including PCO and D&E providers, such turnaround times shall be 95 percent of claims within 14 calendar days and 99 percent of claims in 21 calendar days, provided such claims meet the definition of clean claims, are submitted electronically and meet all HIPAA transaction standards. The date of receipt is the date that the CLTS MCO/SE first receives the claim, either manually or electronically. The CLTS MCO/SE is required to date stamp all claims on the date of receipt. The date of payment is the date of the check or other form of payment. An exception to this rule may be made if the CLTS MCO/SE and its service providers, by mutual agreement, establish an alternative payment schedule. However, any such alternative payment schedule shall first be incorporated into the contract between HSD and the CLTS MCO/SE. The CLTS MCO/SE shall be financially responsible for paying all claims for all covered emergency and post-stabilization services that are furnished by non-contracted service providers, at no more than the medicaid fee-for-service (FFS) rate, including medically or clinically necessary testing to determine if a physical or behavioral health emergency exists.

(1) A CLTS MCO/SE shall pay contracted and noncontracted service providers interest on the CLTS MCO's/SE's liability at the rate of 1.5 percent per month on the amount of a clean claim (based upon the current medicaid fee schedule) submitted by the participating service provider and not paid within 30 days of the date of receipt of an electronic claim, and 45 days of receipt of a manual claim. Interest shall accrue from the 31st day for electronic claims and from the 46th day for manual claims. The CLTS MCO/SE shall be required to report the number of claims and the amount of interest paid, on a timeframe determined by HSD or its designee.

(2) No contract between the CLTS MCO/SE and a participating service provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions.

(3) If the CLTS MCO/SE is unable to determine liability for, or refuses to pay, a claim from a participating service provider within the times specified above, the CLTS MCO/SE shall make a good-faith effort to notify the participating service provider by fax, electronic or other written communication within 30 days of receipt of the claim, stating the specific reasons why it is not liable for the claim, or to request specific information necessary to determine liability for the claim.

D. **Rate setting:** Capitation rates paid by HSD to the CLTS MCO/SE for the provision of the coordinated long-term services benefit package shall be calculated through actuarial analysis, be actuarially sound and meet the standards set by 42 CFR 438.6(c).

E. **Payment on a risk basis:** The CLTS MCO/SE is at risk of incurring losses if its costs of providing the coordinated long-term services benefit package exceed its capitation payment. HSD shall not provide retroactive payment adjustments to the CLTS MCO/SE to reflect the actual cost of services furnished by the CLTS MCO/SE.

F. **Change in capitation rates:** HSD shall review the capitation rates 12 months from the effective date of the contract and annually thereafter. HSD may adjust the capitation rates based on factors such as the following: changes in the scope of work; federal requirement for modification of a waiver; new or amended federal or state laws or regulations are implemented; inflation; or if significant changes in the demographic characteristics of the member population occur.

G. **Solvency requirements and risk protections:** A CLTS MCO/SE that contracts with HSD to provide coordinated long-term health services shall comply with, and be subject to, all applicable state and federal laws and regulations, including solvency and risk standards. In addition to requirements imposed by state and federal law, the CLTS MCO/SE shall be required to meet specific medicaid financial requirements and to provide to HSD the information and records necessary to determine the CLTS MCO's/SE's financial condition. Requests for information and records shall be delivered to HSD or its designee, at no cost to HSD, in a reasonable time after the date of request or as specified in the contract.

(1) **Reinsurance:** A CLTS MCO participating in the coordinated long-term services program shall purchase reinsurance at a minimum of one million dollars ($1,000,000.00) in reinsurance protection against financial loss due to outlier (catastrophic) cases. The CLTS MCO shall provide documentation to HSD or its designee that reinsurance is in effect through the term of the contract and that the amount of reinsurance is sufficient to cover probable outlier cases or overall member utilization at an amount greater than expected. Pursuant to 42 CFR 438.6(e)(5), contract provisions for reinsurance, stop-loss limits, and other risk-sharing methodologies shall be computed on an actuarially sound basis.

(2) **Third party liability (TPL):** The CLTS MCO/SE shall be responsible for identifying a member's third party coverage and coordinating benefits with third parties as required by federal law. The CLTS MCO/SE shall inform HSD or its designee when a member has other health care insurance coverage. The CLTS MCO shall have the sole right of subrogation, for 12 months from when it incurred the cost on behalf of the member, to initiate recovery or to attempt to recover any third-party resources available to medicaid members; and shall make records pertaining to third party collections for members available to HSD or its designee for audit and review. If the CLTS MCO has not initiated recovery or attempted to recover any third-party resources available to medicaid members within 12 months, HSD will pursue the member's third party resources. The CLTS MCO/SE shall provide to HSD or its designee for audit and review all records pertaining to TPL collections for its members.

(3) **Fidelity bond requirement:** The CLTS MCO/SE shall maintain a fidelity bond in the maximum amount specified under the Insurance Code.

(4) **Net worth requirement:** The CLTS MCO/SE shall comply with the net worth requirements of the Insurance Code.

(5) **Solvency cash reserve requirement:** The CLTS MCO/SE shall have sufficient reserve funds available to ensure that the provision of services to medicaid members is not at risk in the event of CLTS MCO/SE insolvency.

(6) **Per enrollee cash reserve:** The CLTS MCO/SE shall maintain three percent of the monthly capitation payments per member with an independent trustee during each month of the agreement. HSD shall adjust this cash reserve requirement annually, or as needed, based on the number of CLTS MCO/SE members, or the failure of the CLTS MCO/SE to maintain a cash reserve equal to three percent, and shall notify the CLTS MCO/SE of the cash reserve requirement. Each CLTS MCO/SE shall maintain its own cash reserve account. This account may be accessed solely for payment of services to the CLTS MCO's/SE's members in the event that the CLTS MCO/SE becomes insolvent. Money in the reserve account remains the property of the CLTS MCO/SE, and any interest earned (even if retained in the account) shall be the property of the CLTS MCO/SE.

(7) The CLTS MCO may satisfy all or part of the insolvency reserve requirements under paragraph (6) of Section G of 8.307.11.9 NMAC in writing with evidence

of adequate protection through any combination of the following that must be approved by the state: net worth of the CLTS MCO (exclusive of any restricted cash reserve); performance guarantee; insolvency insurance; irrevocable letter of credit; surety bond; or a formal written guarantee from the CLTS MCO's parent organization. At least 50 percent of the total insolvency reserve must be restricted cash reserves.

H. **Inspection and audit for solvency requirements:** The CLTS MCO/SE shall meet all requirements for state licensure with respect to inspection and auditing of financial records. The CLTS MCO/SE shall provide to HSD or its designee all financial records required by HSD. HSD, or its designee, may inspect and audit the CLTS MCO's/SE's financial records at least annually or at HSD discretion.

I. **Special payment requirements:** This section lists special payment requirements by service provider type:

(1) **Reimbursement for federally qualified health centers (FQHCs):** Under federal law, FQHCs shall be reimbursed at 100% of reasonable cost under a medicaid FFS or managed care program. The FQHC may waive its right to 100% of reasonable cost and elect to receive a rate negotiated with the CLTS MCO/SE. HSD shall provide a discounted wrap-around payment to FQHCs that have waived a right to 100 percent reimbursement of reasonable cost from the CLTS MCO/SE.

(2) **Reimbursement for providers furnishing services to Native Americans:** If an Indian health service (IHS) or tribal 638 provider delivers services to a CLTS MCO/SE member who is Native American, the CLTS MCO/SE shall reimburse the provider at the rate established by the office of management and budget (OMB) for specified services at IHS facilities, except when otherwise specified by HSD.

(3) **Reimbursement for family planning services:** The CLTS MCO shall reimburse out-of-network family planning providers for services provided to its members at a rate at least equal to the medicaid FFS rate for the provider type.

(4) **Reimbursement for women in the third trimester of pregnancy:** If a woman in the third trimester of pregnancy at the time of her enrollment in coordinated long-term services has an established relationship with an obstetrical provider and desires to continue that relationship, and the provider is not contracted with the CLTS MCO, the CLTS MCO shall reimburse the out-of-network provider for services directly related to the pregnancy, including delivery and a six-week post-partum visit.

(5) **Reimbursement for members who disenroll while hospitalized:** If a medicaid member is hospitalized at the time of disenrollment, the organization that was originally responsible for the hospital impatient placement, shall remain financially responsible for payment of all covered inpatient facility and professional services from the date of admission to the date of discharge, or upon transfer to a lower level of care. Upon discharge, the member will then become the financial responsibility of the organization receiving capitation payments.

(6) **Sanctions for noncompliance:** HSD may impose financial penalties or sanctions against a CLTS MCO/SE that fails to meet the financial requirements specified in this section or additional requirements specified in the terms of the medicaid coordinated long-term services contract or federal medicaid law.

J. **Recoupment payments:** HSD shall recoup payments for CLTS MCO members who are incorrectly enrolled with more than one CLTS MCO; payments made for CLTS MCO/SE members who die prior to the enrollment month for which payment was made; or payments to the CLTS MCO/SE for members whom HSD later determines were not eligible for medicaid during the enrollment month for which payment was made. Any duplicate payment identified by either the CLTS MCO/SE or HSD shall be recouped upon identification. In the event of an error that causes payment(s) to the CLTS MCO/SE to be issued by HSD, HSD shall recoup the full amount of the payment. HSD shall provide the CLTS MCO/SE with a detailed listing of specific members and the associated recoupment for each on a monthly basis, if applicable. Interest shall accrue at the statutory rate on any amounts not paid and determined to be due after the 30th day following the notice. Any process that automates recoupment procedures shall be discussed in advance by HSD and the CLTS MCO/SE, and documented in writing prior to implementation of the new automated recoupment process. The CLTS MCO/SE has the right to dispute any recoupment action in accordance with contractual provisions.

K. HSD shall pay interest at nine percent per annum on any capitation payment due to the CLTS MCO/SE that is more than 30 days late. No interest or penalty shall accrue for any other late payments or reimbursements.

L. HSD may initiate an alternate payment methodology for specified program services or responsibilities.

[8.307.11.9 NMAC - N, 8-1-08]

HISTORY OF 8.307.11 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG TERM SERVICES
PART 12 MEMBER GRIEVANCE RESOLUTION

8.307.12.1 ISSUING AGENCY: Human Services Department
[8.307.12.1 NMAC - N, 8-1-08]

8.307.12.2 SCOPE: This rule applies to the general public.
[8.307.12.2 NMAC - N, 8-1-08]

8.307.12.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.307.12.3 NMAC - N, 8-1-08]

8.307.12.4 DURATION: Permanent
[8.307.12.4 NMAC - N, 8-1-08]

8.307.12.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.12.5 NMAC - N, 8-1-08]

8.307.12.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.12.6 NMAC - N, 8-1-08]

8.307.12.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.12.7 NMAC - N, 8-1-08]

8.307.12.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.12.8 NMAC - N, 8-1-08]

8.307.12.9 GENERAL REQUIREMENTS FOR GRIEVANCES AND APPEALS:

A. The coordinated long-term services managed care organization (CLTS MCO) and single statewide entity (SE) shall have a grievance system in place for members that includes a grievance process related to dissatisfaction and an appeals process related to a CLTS MCO/SE action, including the opportunity to request

a human services department (HSD) fair hearing.

B. The CLTS MCO/SE shall implement written policies and procedures describing how the member may submit a request for a grievance or an appeal with the CLTS MCO/SE, or submit a request for a fair hearing with HSD. The policy shall include a description of how the CLTS MCO/SE resolves the grievance or appeal.

C. The CLTS MCO/SE shall provide to all service providers in the CLTS MCO's/SE's network a written description of its grievance and appeal process and how providers can submit a grievance or appeal for a member or on their own behalf.

D. The CLTS MCO/SE shall make available reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

E. The CLTS MCO/SE shall name a specific individual(s) designated as the CLTS MCO's/SE's medicaid member grievances or appeals coordinator with the authority to administer the policies and procedures for resolution of a grievance or appeal, to review patterns/trends in grievances or appeals, and to initiate corrective action.

F. The CLTS MCO/SE shall ensure that the individuals who make decisions on grievances or appeals are not involved in any previous level of review or decision-making. The CLTS MCO/SE shall also ensure that health care professionals with appropriate clinical expertise shall make decisions for the following:

(1) an appeal of a CLTS MCO/SE denial that is based on lack of medical necessity;

(2) a CLTS MCO/SE denial that is upheld in an expedited resolution; and

(3) a grievance or appeal that involves clinical issues.

G. Upon enrollment, the CLTS MCO/SE shall provide members, at no cost, with a member information sheet or handbook that provides information on how they or their representative(s) can file a grievance or an appeal, and the resolution process. The member information shall also advise members of their right to file a request for an administrative hearing with the HSD fair hearings bureau, upon notification of a CLTS MCO/SE action, or concurrent with, subsequent to or in lieu of an appeal of the CLTS MCO/SE action. The information shall meet the standards specified in Paragraph (12) of Subsection A of 8.307.8.15 NMAC, *members' rights*.

H. The CLTS MCO/SE shall ensure that punitive or retaliatory action is not taken against a member or service provider that files a grievance or an appeal, or a provider that supports a member's grievance or appeal.

[8.307.12.9 NMAC - N, 8-1-08]

8.307.12.10 GRIEVANCE: A grievance is an expression of dissatisfaction about any matter or aspect of the CLTS MCO/SE or its operation, other than a CLTS MCO/SE action.

A. A member may file a grievance either orally or in writing with the CLTS MCO/SE within 90 calendar days of the date of the event causing the dissatisfaction. The legal guardian of the member for a minor or an incapacitated adult, a representative of the member as designated in writing to the CLTS MCO/SE, or a service provider acting on behalf of the member and with the member's written consent, have the right to file a grievance on behalf of the member.

B. Within five working days of receipt of the grievance, the CLTS MCO/SE shall provide the grievant with written notice that the grievance has been received and the expected date of its resolution.

C. The investigation and final CLTS MCO/SE resolution process for grievances shall be completed within 30 calendar days of the date the grievance is received by the CLTS MCO/SE and shall include a resolution letter to the grievant.

D. The CLTS MCO/SE may request an extension from HSD or its designee of up to 14 calendar days if the member requests the extension, or the CLTS MCO/SE demonstrates to HSD that there is need for additional information and the extension is in the member's interest. For any extension not requested by the member, the CLTS MCO/SE shall give the member written notice of the reason for the extension within two working days of the decision to extend the timeframe.

E. Upon resolution of the grievance, the CLTS MCO/SE shall mail a resolution letter to the member. This resolution letter may not take the place of the acknowledgment letter referred to in Section B of 8.307.12.10 NMAC above. The resolution letter shall include, but not be limited to, the following:

(1) all information considered in investigating the grievance;

(2) findings and conclusions based on the investigation; and

(3) the disposition of the grievance.

[8.307.12.10 NMAC - N, 8-1-08]

8.307.12.11 APPEALS: An appeal is a request for review by the CLTS MCO/SE of a CLTS MCO/SE action.

A. An action is defined as:

(1) the denial or limited authorization of a requested service, including the type or level of service;

(2) the reduction, suspension, or termination of a previously authorized service;

(3) the denial, in whole or in part, of payment for a service;

(4) the failure of the CLTS MCO/SE to provide services in a timely manner, as defined by HSD or its designee; or

(5) the failure of the CLTS MCO/SE to complete the authorization request in a timely manner as defined in 42 CFR 438.408.

B. **Notice of CLTS MCO/SE action:** The CLTS MCO/SE shall mail a notice of action to the member or service provider within 10 days of the date of the action for previously authorized services as permitted under 42 CFR 431.213 and 431.214, and within 14 days of the date of the action for newly requested services. Denials of claims that may result in member financial liability require immediate notification. The notice shall contain, but not be limited to, the following:

(1) the action the CLTS MCO/SE has taken or intends to take;

(2) the reasons for the action;

(3) the member's or the service provider's right, as applicable, to file an appeal of the CLTS MCO/SE action through the CLTS MCO/SE;

(4) the member's right to request an HSD fair hearing and what the process would be;

(5) the procedures for exercising the rights specified;

(6) the circumstances under which expedited resolution of an appeal is available and how to request it;

(7) the member's right to have benefits continue pending resolution of an appeal or fair hearing, how to request the continuation of benefits, and the circumstances under which the member may be required to pay the costs of continuing these benefits.

C. A member may file an appeal of a CLTS MCO/SE action within 90 calendar days of receiving the CLTS MCO's/SE's notice of action. The legal guardian of the member for a minor or an incapacitated adult, a representative of the member as designated in writing to the CLTS MCO/SE, or a service provider acting on behalf of the member with the member's written consent, have the right to file an appeal of an action on behalf of the member. The CLTS MCO/SE shall consider the member, representative, or estate representative of a deceased member as parties to the appeal.

D. The CLTS MCO/SE has 30 calendar days from the date the initial oral or written appeal is received by the CLTS MCO/SE to resolve the appeal. The CLTS MCO/SE shall appoint at least one person to review the appeal who was not involved in the initial decision and who is not the subordinate of any person involved in the initial decision.

E. The CLTS MCO/SE shall have a process in place that ensures that an oral or written inquiry from a member seeking to appeal an action is treated as an appeal (to establish the earliest possible filing date for the appeal). An oral appeal shall be followed by a written appeal that is signed by the member within 10 calendar days. The CLTS MCO/SE shall use its best efforts to assist members as needed with the written appeal and may continue to process the appeal.

F. Within five working days of receipt of the appeal, the CLTS MCO/SE shall provide the grievant with written notice that the appeal has been received and the expected date of its resolution. The CLTS MCO/SE shall confirm in writing receipt of oral appeals, unless the member or the service provider requests an expedited resolution.

G. The CLTS MCO/SE may extend the 30-day timeframe by 14 calendar days if the member requests the extension, or the CLTS MCO/SE demonstrates to HSD that there is need for additional information, and the extension is in the member's interest. For any extension not requested by the member, the CLTS MCO/SE shall give the member written notice of the extension and the reason for the extension within two working days of the decision to extend the timeframe.

H. The CLTS MCO/SE shall provide the member or the member's representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing.

I. The CLTS MCO/SE shall provide the member or the representative the opportunity, before and during the appeals process, to examine the member's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the appeals process. The CLTS MCO/SE shall include as parties to the appeal the member and his or her representative, or the legal representative of a deceased member's estate.

J. For all appeals, the CLTS MCO/SE shall provide written notice within the 30-calendar-day timeframe for resolutions to the member or the service provider, if the provider filed the appeal.

(1) The written notice of the appeal resolution shall include, but not be limited to, the following information:

(a) the results and reasoning behind the appeal resolution; and

(b) the date it was completed.

(2) The written notice of the appeal resolution for appeals not resolved wholly in favor of the member shall include, but not be limited to, the following information:

(a) the right to request an HSD fair hearing and how to do so;

(b) the right to request receipt of benefits while the hearing is pending, and how to make the request; and

(c) that the member may be held liable for the cost of continuing benefits if the hearing decision upholds the CLTS MCO's/SE's action.

K. The CLTS MCO/SE may continue benefits while the appeal or the HSD fair hearing process is pending.

(1) The CLTS MCO/SE shall continue the member's benefits if all of the following are met:

(a) the member or the service provider files a timely appeal of the CLTS MCO/SE action or the member asks for a fair hearing within 13 days from the date on the CLTS MCO/SE notice of action;

(b) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(c) the services were ordered by an authorized service provider;

(d) the time period covered by the original authorization has not expired; and

(e) the member requests extension of the benefits.

(2) The CLTS MCO/SE shall provide benefits until one of the following occurs:

(a) the member withdraws the appeal;

(b) 13 days have passed since the date of the resolution letter, provided the resolution of the appeal was against the member and the member has taken no further action;

(c) HSD issues a hearing decision adverse to the member; and

(d) the time period or service limits of a previously authorized service has expired.

(3) If the final resolution of the appeal is adverse to the member, that is, the CLTS MCO's/SE's action is upheld, the CLTS MCO/SE may recover the cost of the services furnished to the member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b).

(4) If the CLTS MCO/SE or HSD reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending, the CLTS MCO/SE shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

(5) If the CLTS MCO/SE or HSD reverses a decision to deny, limit or delay services and the member received the disputed services while the appeal was pending, the CLTS MCO/SE shall pay for these services.

[8.307.12.11 NMAC - N, 8-1-08]

8.307.12.12 EXPEDITED RESOLUTION OF APPEALS: An expedited resolution of an appeal is an expedited review by the CLTS MCO/SE of a CLTS MCO/SE action.

A. The CLTS MCO/SE shall establish and maintain an expedited review process for appeals when the CLTS MCO/SE determines that allowing the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Such a determination is based on:

(1) a request from the member;

(2) a service provider's support of the member's request;

(3) a service provider's request on behalf of the member; or

(4) the CLTS MCO's/SE's independent determination.

B. The CLTS MCO/SE shall ensure that the expedited review process is convenient and efficient for the member.

C. The CLTS MCO/SE shall resolve the appeal within three working days of receipt of the request for an expedited appeal, if the request meets the definition of expedited in 8.307.12.13 NMAC, *expedited resolution of appeals*. In addition to written resolution notice, the CLTS MCO/SE shall also make reasonable efforts to provide and document oral notice.

D. The CLTS MCO/SE may extend the timeframe by up to 14-calendar days if the member requests the extension, or the CLTS MCO/SE demonstrates to HSD that there is need for additional information and the extension is in the member's interest. For any extension not requested by the member, the CLTS MCO/SE shall give the member written notice of the reason for the delay.

E. The CLTS MCO/SE shall ensure that punitive action is not taken against a member or a service provider who requests an expedited resolution or supports a member's expedited appeal.

F. The CLTS MCO/SE shall provide an expedited resolution, if the request meets the definition of an expedited appeal, in response to an oral or written request from the member or service provider on behalf of the member.

G. The CLTS MCO/SE shall inform the member of the limited time available to present evidence and allegations in fact or law.

H. If the CLTS MCO/SE denies a request for an expedited resolution of an appeal, it shall:

(1) transfer the appeal to the 30-day timeframe for standard resolution, in which the 30-day period begins on the date the CLTS MCO/SE received the original request for appeal; and

(2) make reasonable efforts to give the member prompt oral notice of the denial, and follow up with a written notice within two-calendar days.

I. The CLTS MCO/SE shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.

[8.307.12.12 NMAC - N, 8-1-08]

8.307.12.13 SPECIAL RULE FOR CERTAIN EXPEDITED SERVICE AUTHORIZATION DECISIONS: In the case of expedited service authorization decisions that deny or limit services, the CLTS MCO/SE shall, within 72 hours of receipt of the request for service, automatically file an appeal on behalf of the member, use its best effort, to give the member oral notice of the decision on the automatic appeal and to resolve the appeal.

[8.307.12.13 NMAC - N, 8-1-08]

8.307.12.14 OTHER RELATED PROCESSES:

A. **Information about grievance system to providers and subcontractors:** The CLTS MCO/SE shall provide information specified in 42 CFR 438.10(g)(1) about the grievance system to all service providers and subcontractors at the time they enter into a contract.

B. **Grievance or appeal files:**

(1) All grievance or appeal files shall be maintained in a secure and designated area and be accessible to HSD or its designee, upon request, for review. Grievance or appeal files shall be retained for 10 years following the final decision by the CLTS MCO/SE, HSD, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later.

(2) The CLTS MCO/SE shall have procedures for assuring that files contain sufficient information to identify the grievance or appeal, the date it was received, the nature of the grievance or appeal, notice to the member of receipt of the grievance or appeal, all correspondence between the CLTS MCO/SE and the member, the date the grievance or appeal is resolved, the resolution, the notices of final decision to the member, and all other pertinent information.

(3) Documentation regarding the grievance shall be made available to the member, if requested.

[8.307.12.14 NMAC - N, 8-1-08]

8.307.12.15 PROVIDER GRIEVANCE AND APPEAL PROCESS: The CLTS MCO/SE shall establish and maintain written policies and procedures for the filing of provider grievances and appeals. A service provider shall have the right to file a grievance or an appeal with the CLTS MCO/SE. Provider grievances or appeals shall be resolved within 30-calendar days. If the grievance or appeal is not resolved within 30 days, the CLTS MCO/SE shall request a 14-day extension from the service provider. If the service provider requests the extension, the extension shall be approved by the CLTS MCO/SE. A service provider may not file a grievance or an appeal on behalf of a member without written designation by the member as the member's representative. A service provider shall have the right to file an appeal with the CLTS MCO/SE regarding provider payment or contractual issues. See 8.307.12.13 NMAC for special rules for certain expedited service authorizations.

[8.307.12.15 NMAC - N, 8-1-08]

HISTORY OF 8.307.12 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG TERM SERVICES
PART 13 FRAUD AND ABUSE

8.307.13.1 ISSUING AGENCY: Human Services Department

[8.307.13.1 NMAC - N, 8-1-08]

8.307.13.2 SCOPE: This rule applies to the general public.

[8.307.13.2 NMAC - N, 8-1-08]

8.307.13.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 27-2-12 et. seq.

[8.307.13.3 NMAC - N, 8-1-08]

8.307.13.4 DURATION: Permanent

[8.307.13.4 NMAC - N, 8-1-08]

8.307.13.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.

[8.307.13.5 NMAC - N, 8-1-08]

8.307.13.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.

[8.307.13.6 NMAC - N, 8-1-08]

8.307.13.7 DEFINITIONS: See 8.307.1.7 NMAC.

[8.307.13.7 NMAC - N, 8-1-08]

8.307.13.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.

[8.307.13.8 NMAC - N, 8-1-08]

8.307.13.9 FRAUD AND ABUSE: The human services department (HSD) is committed to the development and implementation of an aggressive prevention, detection, monitoring and investigation program to reduce provider/member fraud and abuse, and member abuse and neglect. If fraud or abuse is discovered, HSD shall seek applicable administrative, civil and criminal penalties, sanctions and other forms of relief. This applies to all individuals participating in or contracting with HSD for provision or receipt of medicaid services. The coordinated long-term services managed care organization (CLTS MCO) and single statewide entity (SE) shall comply with provisions of state and federal fraud and abuse laws and regulations.

[8.307.13.9 NMAC - N, 8-1-08]

8.307.13.10 COORDINATED LONG-TERM SERVICES MANAGED CARE ORGANIZATION REQUIREMENTS: The CLTS MCO/SE shall have in place internal controls, policies and procedures for the prevention, detection, investigation, and reporting of potential fraud and abuse activities concerning service providers and members. The CLTS MCO's/SE's specific internal controls, policies and procedures shall be described in a comprehensive written plan submitted to HSD, or its designee, for approval. Substantive amendments or modifications to the plan shall be approved by HSD or its designee. The CLTS MCO/SE shall maintain procedures for reporting potential and actual fraud and abuse by consumers or service providers to HSD or its designee. The CLTS MCO/SE shall:

A. have internal procedures that facilitate preliminary investigating and reporting of potential and actual fraud and abuse to HSD, or its designee, for

further investigation;

B. have specific controls in place for preventing and detecting potential cases of fraud and abuse, such as claims edits, post processing review of claims, service provider profiling/exception reporting and credentialing, prior authorizations, and utilization/quality management monitoring;

C. have a mechanism to work with HSD, or its designee, to further develop prevention and detection methods and best practices and to monitor outcomes for medicaid coordinated long-term services;

D. have internal procedures to prevent, detect and investigate program violations to recover funds misspent due to fraudulent or abusive actions;

E. report to HSD or its designee the names of all service providers identified with aberrant utilization, according to service provider profiles, regardless of the cause of the aberrancy;

F. designate a compliance officer and a compliance committee that are accountable to senior management;

G. provide effective fraud and abuse detection training, administrative remedies for false claims and statements, and whistleblower protection under such laws to the CLTS MCO's/SE's employees that includes:

(1) written policies for all employees, agents or contractors that provide detailed information regarding the New Mexico Medicaid False Claims Act, NMSA 1978, and the federal False Claims Act established under sections 3729 through 3733 of Title 31, United States code, administrative remedies for false claims and statements established under Chapter 38 of Title 31, United States code, including but not limited to, preventing and detecting fraud, waste and abuse in federal health care programs (as defined in section 1128B (f) of the Social Security Act);

(2) as part of such written policies, detailed provision regarding the CLTS MCO's/SE's policies and procedures for detecting and preventing fraud, waste and abuse; and

(3) in any employee handbook, a specific discussion of the laws described in Paragraph (1) above, the rights of employees to be protected as whistleblowers, and the contractor's or subcontractor's policies and procedures for detecting and preventing fraud, waste and abuse;

H. implement effective lines of communication between the compliance officer and the CLTS MCO's/SE's employees;

I. require enforcement of standards through well-publicized disciplinary guidelines; and

J. have a provision for prompt response to detected offenses and for development of corrective action initiatives relating to the CLTS MCO's/SE's contract.

[8.307.13.10 NMAC - N, 8-1-08]

HISTORY OF 8.307.13 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG TERM SERVICES
PART 14 REPORTING REQUIREMENTS

8.307.14.1 ISSUING AGENCY: Human Services Department

[8.307.14.1 NMAC - N, 8-1-08]

8.307.14.2 SCOPE: This rule applies to the general public.

[8.307.14.2 NMAC - N, 8-1-08]

8.307.14.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.

[8.307.14.3 NMAC - N, 8-1-08]

8.307.14.4 DURATION: Permanent

[8.307.14.4 NMAC - N, 8-1-08]

8.307.14.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.

[8.307.14.5 NMAC - N, 8-1-08]

8.307.14.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.

[8.307.14.6 NMAC - N, 8-1-08]

8.307.14.7 DEFINITIONS: See 8.307.1.7 NMAC.

[8.307.14.7 NMAC - N, 8-1-08]

8.307.14.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.

[8.307.14.8 NMAC - N, 8-1-08]

8.307.14.9 REPORTING REQUIREMENTS: The coordinated long-term services managed care organization (CLTS MCO) and single statewide entity (SE) shall provide to the human services department (HSD) managerial, financial, delegation, suspicious activity, utilization, and quality reports. The content, format and schedule for submission shall be determined by HSD or its designee in writing. HSD or its designee may require the CLTS MCO/SE to prepare and submit ad hoc reports.

[8.307.14.9 NMAC - N, 8-1-08]

8.307.14.10 REPORTING STANDARDS:

A. Reports submitted by the CLTS MCO/SE to HSD shall meet certain standards.

(1) The CLTS MCO/SE shall verify the accuracy of data and other information on reports submitted.

(2) Reports or other required data shall be received on or before scheduled due dates.

(3) Reports or other required data shall conform to HSD's defined standards as specified in writing.

(4) All required information shall be fully disclosed in a manner that is responsive and with no material omission.

(5) The CLTS MCO/SE shall analyze all required reports internally before submitting them to HSD or its designee. The CLTS MCO/SE shall analyze reports for any early patterns of change, identified trends, or outliers (catastrophic cases), and shall submit this analysis with the required reports. The CLTS MCO/SE shall send a written narrative for specified reports with the report documenting the CLTS MCO's/SE's interpretation of early patterns of change, identified trends, or outliers.

B. **Consequences of violation of reporting standards:** The submission of late, inaccurate or otherwise incomplete reports shall be considered failure to report. Sanctions may be imposed by HSD, or its designee, on the CLTS MCO/SE for failure to submit accurate and timely reports.

C. **Changes in requirements:** HSD's requirements regarding reports, report content and frequency of submission may change during the term of the contract. The CLTS MCO/SE shall comply with changes specified by HSD or its designee.

[8.307.14.10 NMAC - N, 8-1-08]

8.307.14.11 MANAGERIAL REPORTS: Managerial reports demonstrate compliance with the operational requirements of the contract. These reports shall include, but not be limited to, information on such topics as:

A. CLTS MCO/SE: composition of current provider networks and

capacity to take new members;

B. CLTS MCO/SE: changes in the composition and capacity of provider networks;

C. CLTS MCO: primary care provider (PCP)-to-member ratios;

D. CLTS MCO/SE: identification of third-party liability;

E. CLTS MCO/SE: grievance system activity;

F. CLTS MCO/SE: fraud and abuse detection activities;

G. CLTS MCO/SE: delegation oversight activities; and

H. CLTS MCO/SE: member satisfaction.

[8.307.14.11 NMAC - N, 8-1-08]

8.307.14.12 FINANCIAL REPORTS: Financial reports demonstrate the CLTS MCO's/SE's ability to meet its commitments under the terms of the contract. The format, content and frequency for submitting financial reports shall be determined by HSD or its designee. The CLTS MCO/SE shall meet the following general requirements:

A. The CLTS MCO shall submit annual audited financial statements, including, but not limited to, its income statement, a statement of changes in financial condition or cash flow and a balance sheet, and shall include an audited schedule of coordinated long-term services revenues and expenses. The SE shall submit annual audited financial statements, including, but not limited to, its income statement, a statement of changes in financial condition or cash flow and a balance sheet, and shall include an audited schedule of coordinated long-term services behavioral health revenues and expenses. The result of the CLTS MCO's/SE's annual audit and related management letters shall be submitted no later than 150 days following the close of the CLTS MCO's/SE's fiscal year. The audit shall be performed by an independent certified public accountant. The CLTS MCO/SE shall submit for examination any financial reports requested by HSD or its designee.

B. The CLTS MCO/SE and their subcontractors shall maintain their accounting systems in accordance with statutory accounting principles, generally accepted accounting principles, or other generally accepted systems of accounting. The accounting system shall clearly document all financial transactions between the CLTS MCO/SE and their subcontractors and the CLTS MCO/SE and HSD. These transactions shall include, but not be limited to, claim payments, refunds and adjustments of payments.

C. The CLTS MCO/SE and their subcontractors shall make available to HSD, and other authorized state or federal agencies, all financial records required to examine compliance by the CLTS MCO/SE, in so far as those records are related to CLTS MCO/SE performance under the contract. The CLTS MCO/SE and their subcontractors shall provide HSD or its designee access to their facilities for the purpose of examining, reviewing and inspecting the CLTS MCO's/SE's records.

D. The CLTS MCO/SE and their subcontractors shall retain all records and reports relating to agreements with HSD for a minimum of 10 years after the date of final payment. In cases involving incomplete audits and unresolved audit findings, administrative sanctions or litigation, the minimum 10-year retention period shall begin on the date such actions are resolved.

E. The CLTS MCO/SE is mandated to notify HSD or its designee immediately when any change in ownership is anticipated. The CLTS MCO/SE shall submit a detailed work plan to the department of insurance during the transition period no later than the date of the sale. The work plan shall identify areas of the contract that may be impacted by the change in ownership, including management and staff. The CLTS MCO/SE shall submit records involving any business restructuring when changes in ownership interest in the CLTS MCO/SE of five percent or more have occurred. These records shall include, but not be limited to, an updated list of names and addresses of all persons or entities having ownership interest in the CLTS MCO/SE of five percent or more. These records shall be provided no later than 60 days following the change in ownership.

[8.307.14.12 NMAC - N, 8-1-08]

8.307.14.13 UTILIZATION AND QUALITY MANAGEMENT REPORTING: Utilization and quality management reports shall demonstrate compliance with HSD's service delivery and quality standards. These reports shall include, but not be limited to:

A. regular reporting that describes critical incidents as specified by HSD or its designee; for this purpose, critical incidents contribute to a trend that has a negative impact on areas such as quality of services, access to services or service delivery as defined by HSD or its designee;

B. regular reporting of encounter data as specified by HSD or its designee;

C. regular reporting of utilization management activity; and

D. other required reports as determined by HSD or its designee, including, but not limited to, performance and tracking measures.

[8.307.14.13 NMAC - N, 8-1-08]

HISTORY OF 8.307.14 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG TERM SERVICES
PART 15 SERVICES FOR MEMBERS WITH SPECIAL HEALTH CARE NEEDS

8.307.15.1 ISSUING AGENCY: Human Services Department

[8.307.15.1 NMAC - N, 8-1-08]

8.307.15.2 SCOPE: This rule applies to the general public.

[8.307.15.2 NMAC - N, 8-1-08]

8.307.15.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.

[8.307.15.3 NMAC - N, 8-1-08]

8.307.15.4 DURATION: Permanent

[8.307.15.4 NMAC - N, 8-1-08]

8.307.15.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.

[8.307.15.5 NMAC - N, 8-1-08]

8.307.15.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.

[8.307.15.6 NMAC - N, 8-1-08]

8.307.15.7 DEFINITIONS: See 8.307.1.7 NMAC.

[8.307.15.7 NMAC - N, 8-1-08]

8.307.15.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.

[8.307.15.8 NMAC - N, 8-1-08]

8.307.15.9 SERVICES FOR INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS (ISHCN):

A. ISHCN require a broad range of primary, specialized medical, behavioral health and related services. ISHCN are individuals who have, or are at

an increased risk for, a chronic physical, developmental, behavioral, neurobiological, or emotional condition, or low to severe functional limitation, and who also require health and related services of a type or amount beyond that required by other individuals. ISHCN have ongoing health conditions, high or complex service utilization, and low to severe functional limitations. The primary purpose of the definition is to identify these individuals so that the CLTS MCO/SE can facilitate access to appropriate services. The definition also allows for flexible targeting of individuals based on clinical justification and discontinuing targeted efforts when such efforts are no longer needed.

B. **Identification of enrolled ISHCN:** The CLTS MCO/SE shall have written policies and procedures in place, with the human services department's (HSD's) or its designee's approval, that govern how members with multiple and complex physical and behavioral health service needs shall be identified. The CLTS MCO/SE shall have an internal operational process, in accordance with policies and procedures, to target members for the purpose of applying stratification criteria to identify ISHCN. The CLTS MCO/SE shall employ reasonable efforts to identify ISHCN based at least on the following criteria:

(1) individuals eligible for supplemental security income (SSI);

(2) individuals enrolled in the home-based waiver programs;

(3) children receiving foster care or adoption assistance support;

(4) individuals identified by service utilization, clinical assessment, or diagnosis; and

(5) referral by family or a public or community program.

[8.307.15.9 NMAC - N, 8-1-08]

8.307.15.10 COORDINATED LONG-TERM SERVICES ENROLLMENT FOR ISHCN:

A. **Switch enrollment:** The CLTS MCO shall have policies and procedures to facilitate a smooth transition for members who switch enrollment to another CLTS MCO. See Subsection G of 8.307.5.9 NMAC, *member switch enrollment*. Members, including ISHCN, may request to break a lock-in and be switched to membership in another CLTS MCO, based on cause. The member or the member's family or legal guardian shall contact HSD or its designee to request that the member be switched to another CLTS MCO.

B. **ISHCN information and education:**

(1) The CLTS MCO/SE shall develop and distribute information and materials specific to the needs of ISHCN to ISHCN members, caregivers, and parents or legal guardians, as appropriate. This includes information such as items and services that are provided or not provided by the coordinated long-term services program, how to arrange transportation, and which services require a referral from the member's primary care provider (PCP). The individual, family, caregiver, or legal guardian shall be informed on how to present an individual for services in an emergency room that is unfamiliar with the individual's special health service needs, and about the availability of service coordination. See 8.307.9 NMAC, *Coordination of Services*. This information may be included in either a special member handbook or in an ISHCN insert to the CLTS MCO/SE member handbook.

(2) The CLTS MCO/SE shall provide health education information to assist an ISCHN or caregivers in understanding how to cope with the day-to-day stress caused by chronic illness, including chronic behavioral health conditions.

(3) The CLTS MCO/SE shall provide ISHCN or caregivers a list of key CLTS MCO/SE resource people and their telephone numbers. The CLTS MCO/SE shall designate a single point of contact that an ISHCN member, family member, caregiver, or service provider may call for information.

[8.307.15.10 NMAC - N, 8-1-08]

8.307.15.11 CHOICE OF SPECIALIST AS PCP: The CLTS MCO shall develop and implement policies and procedures governing the process for member selection of a PCP, including the right by an ISHCN to choose a specialist as a PCP. The specialist provider must agree to be the PCP.

[8.307.15.11 NMAC - N, 8-1-08]

8.307.15.12 SPECIALTY PROVIDERS FOR ISHCN: The CLTS MCO/SE shall have policies and procedures in place to allow direct access to necessary specialty services, consistent with coordinated long-term services access appointment standards for clinical urgency, including behavioral health access standards. See 8.307.8.18 NMAC, s*tandards for access*.

[8.307.15.12 NMAC - N, 8-1-08]

8.307.15.13 TRANSPORTATION FOR ISHCN: The CLTS MCO shall:

A. have written policies and procedures in place to ensure that the appropriate level of transportation is arranged, based on the individual's clinical condition;

B. have past member service data available at the time services are requested to expedite appropriate arrangement;

C. ensure that CPR-certified drivers transport ISHCN if clinically indicated;

D. have written policies and procedures to ensure that the transportation mode is clinically appropriate, including access to non-emergency ground carriers;

E. develop and implement written policies and procedures to ensure that individuals can access and receive authorization for needed transportation services under certain unusual circumstances without the usual advance notification;

F. develop and implement a written policy regarding the transportation of minors to ensure the minor's safety;

G. distribute clear and detailed written information to ISHCN and, if needed, to their caregivers, on how to obtain transportation services, and also make this information available to network providers; and

H. coordinate transportation needs with the SE; the SE shall also coordinate the transportation needs of its population with the member's respective CLTS MCO.

[8.307.15.13 NMAC - N, 8-1-08]

8.307.15.14 SERVICE COORDINATION FOR ISHCN: The CLTS MCO/SE shall develop policies and procedures to provide service coordination for ISHCN. Refer to Section 8.307.9.9 NMAC, *coordination of services*, for definition.

A. The CLTS MCO/SE shall have an internal operational process, in accordance with policies and procedures, to target medicaid members for purposes of applying stratification criteria to identify those who are potential ISHCN. The contractor shall provide HSD or its designee with the applicable policies and procedures describing the targeting and stratification process.

B. The CLTS MCO/SE shall have written policies and procedures to ensure that each member identified as having special health care needs is assessed by an appropriate health care professional regarding the need for service coordination. If the member has both physical and behavioral health special needs, the CLTS MCO and SE shall coordinate services in a timely and collaborative manner.

C. The CLTS MCO/SE shall have written policies and procedures for educating ISHCN needs and, in the case of children with special health care needs, parent and legal guardians, that service coordination is available and when it may be appropriate to their needs.

[8.307.15.14 NMAC - N, 8-1-08]

8.307.15.15 EMERGENCY, INPATIENT AND OUTPATIENT AMBULATORY SURGERY HOSPITAL REQUIREMENTS FOR ISHCN: The CLTS MCO/SE shall develop and implement policies and procedures for:

A. educating ISHCN members, ISHCN family members or caregivers on how to access emergency room services and what clinical history to provide when emergency services or inpatient admission are needed, including behavioral health emergency services;

B. how coordination with the PCP, the SE (if applicable) and the hospitalist shall occur when an ISHCN is hospitalized;

C. ensuring that the emergency room physician has access to the individual's medical clinical history; and

D. obtaining any necessary referrals from PCPs for inpatient hospital staff providing outpatient or ambulatory surgical procedures.

[8.307.15.15 NMAC - N, 8-1-08]

8.307.15.16 REHABILITATION THERAPY SERVICES (PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY) FOR ISHCN: The CLTS MCO shall:

A. develop and implement therapies using clinical practice guidelines specific to acute, chronic or long-term conditions of their ISHCN, that meet medical necessity criteria and are based on HSD's children and adult rehabilitation services policy;

B. be knowledgeable about and coordinate with the home and community-based waiver programs or the schools regarding other therapy services being provided to the ISHCN in order to avoid duplication of services;

C. involve the ISHCN's family, caregivers, physicians and therapy service providers in identifying issues to be included in the plan of services; and

D. develop and implement utilization prior authorization and continued stay criteria, including time frames, that are appropriate to the chronicity of the member's status and anticipated development process.

[8.307.15.16 NMAC - N, 8-1-08]

8.307.15.17 DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES FOR ISHCN: The CLTS MCO shall:

A. develop and implement a process to permit members utilizing supplies on an ongoing basis to submit a list of supplies to the DME service provider on a monthly basis; the CLTS MCO shall contact the member or the member's legal guardian or caregiver when requested supplies cannot be delivered and make other arrangements, consistent with clinical need;

B. develop and implement a system for monitoring compliance with access standards for DME and medical supplies, and institute corrective action if the service provider is out of compliance; and

C. have an emergency response plan for DME and medical supplies needed on an emergent basis.

[8.307.15.17 NMAC - N, 8-1-08]

8.307.15.18 CLINICAL PRACTICE GUIDELINES FOR PROVISION OF SERVICES TO ISHCN: The CLTS MCO/SE shall develop clinical practice guidelines, practice parameters and other criteria that consider the needs of ISHCN and provide guidance in the provision of acute and chronic physical and behavioral health care services to this population. The guidelines should be based on professionally accepted standards of practice and national guidelines.

[8.307.15.18 NMAC - N, 8-1-08]

8.307.15.19 UTILIZATION MANAGEMENT FOR SERVICES TO ISHCN: The CLTS MCO/SE shall develop written policies and procedures to exclude from prior authorization any item of service identified in the course of treatment or extend the authorization periodicity for services provided for chronic conditions. There shall be a process for review and periodic update for the course of treatment, as indicated.

[8.307.15.19 NMAC - N, 8-1-08]

8.307.15.20 ADDITIONS TO CONSUMER ASSESSMENT OF HEALTH PLANS SURVEY (CAHPS) FOR ISHCN: The CLTS MCO shall add questions about ISHCN to the most current health plan employer data and information set (HEDIS) CAHPS survey.

[8.307.15.20 NMAC - N, 8-1-08]

8.307.15.21 ISHCN PERFORMANCE MEASURES: The CLTS MCO/SE shall initiate a quality strategy related to ISHCN within its annual quality management plan utilizing a performance measure specific to ISHCN. See 8.307.8 NMAC, *Quality Management*.

[8.307.15.21 NMAC - N, 8-1-08]

HISTORY OF 8.307.15 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG TERM SERVICES
PART 16 CLIENT TRANSITION OF CARE

8.307.16.1 ISSUING AGENCY: Human Services Department
[8.307.16.1 NMAC - N, 8-1-08]

8.307.16.2 SCOPE: This rule applies to the general public.
[8.307.16.2 NMAC - N, 8-1-08]

8.307.16.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.307.16.3 NMAC - N, 8-1-08]

8.307.16.4 DURATION: Permanent
[8.307.16.4 NMAC - N, 8-1-08]

8.307.16.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.16.5 NMAC - N, 8-1-08]

8.307.16.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.16.6 NMAC - N, 8-1-08]

8.307.16.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.16.7 NMAC - N, 8-1-08]

8.307.16.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.16.8 NMAC - N, 8-1-08]

8.307.16.9 MEMBER TRANSITION OF SERVICES: The coordinated long-term services managed care organization (CLTS MCO) and single statewide entity (SE) shall have the resources, policies and procedures in place to ensure continuity of services without disruption in service to members and to assure the service provider of payment. The CLTS MCO/SE shall actively assist members, in particular indi-

viduals with special health care needs (ISHCN). Members transitioning from institutional levels of care such as hospitals, nursing homes, or residential treatment facilities back to community services with transition of service needs shall be offered care coordination services as indicated. Medicaid-eligible members may initially receive physical and behavioral health services under fee-for-service (FFS) medicaid prior to enrollment in coordinated long-term services. During the member's medicaid eligibility period, enrollment status with a particular CLTS MCO may change and the member may switch enrollment to a different CLTS MCO. Certain members covered under coordinated long-term services may become exempt and other members may lose their medicaid eligibility while enrolled in a CLTS MCO/SE. A member changing from one CLTS MCO to another CLTS MCO, or from FFS to coordinated long-term services or vice versa shall continue to receive medically necessary services in an uninterrupted manner.

A. **Member transition:** The CLTS MCO/SE shall have policies and procedures that address member identification and the clinical transition and transfer of members into or out of the CLTS MCO.

(1) The CLTS MCO shall have policies and procedures that cover potentially large or mass transfer of members into or out of the CLTS MCO, including the identification of members currently receiving services, and notification of the statewide entity (SE).

(2) The CLTS MCO shall have policies and procedures that address the transition into the CLTS MCO of an individual member, including member and provider education about the CLTS MCO and the review and update of existing courses of treatment. The SE shall be notified and coordination of care shall occur.

(3) The CLTS MCO shall have policies and procedures that identify members transferring out of the CLTS MCO and ensure the provision of member data and clinical information to the future CLTS MCO necessary to avoid delays in member treatment. The CLTS MCO shall have written policies and procedures to facilitate a smooth transition of a member to another CLTS MCO when a member chooses and is approved to switch to another CLTS MCO.

(4) The CLTS MCO/SE shall have policies and procedures regarding provider responsibilities for discharge planning upon the member's discharge from an inpatient or residential treatment facility, and the CLTS MCO/SE shall help coordinate for a seamless transition of post-discharge care.

B. **Prior authorization and provider payment requirements:**

(1) For newly enrolled members, the CLTS MCO shall honor all prior authorizations granted by the human services department (HSD) through its contractors, including the SALUD! contractors, for the first 60 days of enrollment or until the CLTS MCO has made other arrangements for the transition of services. Providers who delivered services approved by HSD through its contractors shall be reimbursed by the CLTS MCO. The SE shall honor all prior authorizations for 30 days or until other arrangements can be made.

(2) For members who recently became exempt from coordinated long-term services, HSD shall honor prior authorization of FFS covered benefits granted by the CLTS MCO/SE for the first 30 days under FFS medicaid or until other arrangements for the transition of services have been made. Providers that deliver these services and are eligible and willing to enroll as medicaid FFS providers shall be reimbursed by HSD.

(3) For members who had transplant services approved by HSD under FFS, the CLTS MCO shall reimburse the service providers approved by HSD if a donor organ becomes available for the member during the first 30 days of enrollment.

(4) For members who had transplant services approved by the CLTS MCO, HSD shall reimburse the service providers approved by the CLTS MCO if a donor organ becomes available for the member during the first 30 days under FFS medicaid. Service providers who deliver these services shall be eligible and willing to enroll as medicaid FFS providers.

(5) For newly enrolled members, the CLTS MCO shall pay for prescriptions for drug refills for the first 90 days or until the CLTS MCO has made other arrangements. The SE shall pay for all prescriptions for 30 days or until other arrangements are made. All drugs prescribed by a licensed behavioral health service provider shall be paid for by the SE.

(6) For members who recently became exempt from coordinated long-term services, HSD shall pay for prescriptions for drug refills for the first 30 days under the FFS formulary. The pharmacy provider shall be eligible and willing to enroll as a medicaid FFS provider.

(7) The CLTS MCO shall pay for durable medical equipment (DME) costing $2,000 or more, approved by the CLTS MCO but delivered to the member after disenrollment from coordinated long-term services.

(8) HSD shall pay for DME costing $2,000 or more, approved by HSD but delivered to the member after enrollment in the CLTS MCO. The DME service provider shall be eligible for and willing to enroll as a medicaid FFS provider. DME is not covered by the SE unless it has been prescribed by a behavioral health service provider.

C. **Special payment requirement:** The CLTS MCO shall be responsible for payment of covered physical health services provided to the member for any month during which the CLTS MCO receives a capitation payment. The SE shall be responsible for payment of covered behavioral health services provided to the member for any month the SE receives a capitation payment.

D. **Claims processing and payment:** In the event that the CLTS MCO's/SE's contract with HSD or the collaborative has ended, is not renewed or is terminated, the CLTS MCO/SE shall remain responsible for processing and paying claims for services delivered through the contract period, but submitted after the CLTS MCO's/SE's contract has ended.

(1) The CLTS MCO/SE shall be required to inform service providers in writing, at least 30 days prior to the end of the contract, of the termination of the contract and of the process for service providers to submit claims for services provided through the contract end date. The letter shall include the telephone, fax numbers, and the billing address for claims submissions, as well as the names of persons to contact with questions.

(2) The CLTS MCO/SE shall allow six months to process claims for services provided prior to the contract termination date.

(3) The CLTS MCO/SE shall continue to meet timeframes established for processing all claims.

[8.307.16.9 NMAC - N, 8-1-08]

HISTORY OF 8.307.16 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG TERM SERVICES
PART 17 VALUE ADDED SERVICES

8.307.17.1 ISSUING AGENCY: Human Services Department
[8.307.17.1 NMAC - N, 8-1-08]

8.307.17.2 SCOPE: This rule applies to the general public.
[8.307.17.2 NMAC - N, 8-1-08]

8.307.17.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to

regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.307.17.3 NMAC - N, 8-1-08]

8.307.17.4 DURATION: Permanent
[8.307.17.4 NMAC - N, 8-1-08]

8.307.17.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.17.5 NMAC - N, 8-1-08]

8.307.17.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.17.6 NMAC - N, 8-1-08]

8.307.17.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.17.7 NMAC - N, 8-1-08]

8.307.17.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.17.8 NMAC - N, 8-1-08]

8.307.17.9 VALUE ADDED SERVICES: The coordinated long-term services managed care organization (CLTS MCO) and single statewide entity (SE) shall offer members value added services. The cost of these services cannot be included when the human services department (HSD) determines the payment rates. Value added services are not included in the medicaid coordinated long-term services benefit package. Value added services shall not be construed as medicaid funded services, benefits, or entitlements under the NM Public Assistance Act. Value added services shall be approved by and reported to HSD or its designee. The CLTS MCO/SE shall work with HSD or its designee to identify codes to be used for value added services. Value added services shall be direct services, and not administrative in nature unless approved by HSD or its designee.

A. **Potential value added services (CLTS MCO only):** The following are suggested value added services:

(1) anticipatory guidance provided as a part of the normal course of office visits or a health education program, including behavioral health;

(2) abuse and neglect prevention programs;

(3) stress control programs;

(4) culturally-traditional indigenous healers and treatments;

(5) smoking cessation programs;

(6) weight loss and nutrition programs;

(7) violence prevention services;

(8) service animals, assistive technology that is beyond the benefit package, and pest control;

(9) substance abuse prevention and treatment, beyond the benefit package;

(10) attendant care and homemaker services for dual eligibles who do not meet nursing facility level of care;

(11) home repair and maintenance or environmental modifications for members who are not eligible for 1915 (c) services;

(12) home-delivered meals; and

(13) pharmacy wrap around.

B. **Potential value added services (SE only):** The SE shall strategically determine a continuum of services, identify value added services needs and work with the collaborative to develop value added services. Value added services should promote evidence based practices that support recovery and resiliency.

C. **Member specific value added services:** Other services may be made available to members based on the CLTS MCO's/SE's discretion. Eligibility for value added services may be based upon a set of assessment criteria to be employed by the CLTS MCO/SE.
[8.307.17.9 NMAC - N, 8-1-08]

HISTORY OF 8.307.17 NMAC: [RESERVED]

NEW MEXICO MAIN STREET REVOLVING LOAN COMMITTEE

TITLE 12 TRADE, COMMERCE AND BANKING
CHAPTER 21 COMMUNITY REVITALIZATION AND DEVELOPMENT
PART 2 PROCEDURES OF THE MAIN STREET REVOLVING LOAN COMMITTEE

12.21.2.1 ISSUING AGENCY: Main Street Revolving Loan Committee. Contact State Historic Preservation Division, Department of Cultural Affairs.
[12.21.2.1 NMAC - N, 7/31/08]

12.21.2.2 SCOPE: This rule applies to members of the committee, the state historic preservation officer, the historic preservation division, members of the public having business with the committee, the economic development department, the New Mexico main street program and property owners in New Mexico main street communities.
[12.21.2.2 NMAC - N, 7/31/08]

12.21.2.3 STATUTORY AUTHORITY: Section 3-60C-4 NMSA 1978.
[12.21.2.3 NMAC - N, 7/31/08]

12.21.2.4 DURATION: Permanent.
[12.21.2.4 NMAC - N, 7/31/08]

12.21.2.5 EFFECTIVE DATE: July 31, 2008, unless a later date is cited at the end of a section.
[12.21.2.5 NMAC - N, 7/31/08]

12.21.2.6 OBJECTIVE: This rule of procedure shall serve the public and members of the committee as a guide to the operations and policies of the main street revolving loan committee. The rule shall be used as a reference and guide by all those concerned with observance and enforcement of the Main Street Revolving Loan Act, Sections 3-60C-1 to 3-60C-6 NMSA 1978.
[12.21.2.6 NMAC - N, 7/31/08]

12.21.2.7 DEFINITIONS:

A. "Committee" means the main street revolving loan committee.

B. "Division" means the historic preservation division, department of cultural affairs.

C. "Eligible property" means a site, structure, building or object that is subject to the Main Street Act (3-60B-1 NMSA 1978) or otherwise found pursuant to the rule of the committee to merit preservation pursuant to the main street revolving loan act.

D. "Fund" means the main street revolving loan fund.

E. "Property owner" means the sole owner, joint owner, owner in partnership or an owner of a leasehold interest with a term of five years or longer of an eligible property.
[12.21.2.7 NMAC - N, 7/31/08]

12.21.2.8 THE COMMITTEE:

A. The name of this committee shall be the "main street revolving loan committee," hereinafter referred to as the "committee."

B. The powers and duties of the committee shall be those enumerated in Section 3-60C-4 NMSA 1978.

C. The committee shall promulgate and revise as necessary those rules authorized by the act to effectuate the act.

D. The fiscal year of the committee shall end on June 30.
[12.21.2.8 NMAC - N, 7/31/08]

12.21.2.9 MEMBERS OF THE COMMITTEE:

A. Members of the committee are those appointed pursuant to Section 3-60C-4 NMSA 1978.

B. Members of the committee shall receive per diem and travel compensation as provided by the Per Diem and Mileage Act (Sections 10-8-1 through 10-8-8, NMSA 1978 Comp.) for official meetings or business of the committee.

[12.21.2.9 NMAC - N, 7/31/08]

12.21.2.10 MEETINGS OF THE COMMITTEE:

A. The committee shall meet at the call of the chair but no less than four times per year.

B. Any meeting or hearing of the committee may be held at any place within the state of New Mexico.

C. At each regular meeting of the committee, the committee and the historic preservation division shall agree on the place, date, time, and when appropriate, subject matter of the next meeting. An agenda and any required supporting documents, consistent with this decision, shall be issued by the historic preservation division two weeks prior to each scheduled meeting.

D. Special meetings may be called at any time for a stated purpose, consistent with the current open meetings resolution of the committee, by agreement of the chairman of the committee.

[12.21.2.10 NMAC - N, 7/31/08]

12.21.2.11 ORGANIZATION OF THE COMMITTEE: At the first meeting after the beginning of each fiscal year, the committee shall organize by the election and installation of a chairman, a vice-chairman and a secretary from among its members.

[12.21.2.11 NMAC - N, 7/31/08]

12.21.2.12 DUTIES OF THE OFFICERS AND PERMANENT MEMBERS OF THE COMMITTEE:

A. The chairman shall preside at all meetings and shall appoint all subcommittees. He shall otherwise perform all duties pertaining to the office of the chairman.

B. The vice-chairman shall, in the absence or incapacity of the chairman, exercise the duties and shall possess all the powers of the chairman. In the absence of both the chairman and the vice-chairman, the secretary shall assume said duties and powers.

C. According to the Open Meetings Act Section 10-15-1 NMSA 1978, there will be minutes for the meeting. The historic preservation division may keep the meeting notes on the committee's behalf.

[12.21.2.12 NMAC - N, 7/31/08]

12.21.2.13 MEETING PROCEDURE:

A. The order of business shall be as follows:

(1) approval of agenda;
(2) review of minutes;
(3) chairman's report;
(4) historic preservation division report;
(5) loan applications;
(6) committee matters;
(7) subcommittee matters;
(8) old business;
(9) new business;
(10) date of meetings; and
(11) adjournment.

B. The order of business may be revised or tabled at the discretion of the chairman in order to accommodate the schedules of interested persons who are present to discuss items on the agenda.

C. Standard parliamentary procedure shall govern the proceedings of the committee meetings except as otherwise provided for in this rule. Where a provision in this rule conflicts with standard parliamentary procedure, the provision in this rule shall be followed.

D. A simple majority shall constitute a quorum.

E. At a regular meeting, no member of the committee may participate in a final decision in any matter before the committee unless he has heard the evidence or familiarized himself with the record. Further, such member must be present at said meeting for actual participation in the final decision.

F. The historic preservation division shall send out, two weeks prior to a meeting, an agenda incorporating all matters identified by the division as requiring the attention of the committee. The committee may at its discretion accept any matter for consideration, providing such consideration is not inconsistent with the act and with the current open meetings resolution of the committee.

[12.21.2.13 NMAC - N, 7/31/08]

12.21.2.14 ORGANIZATION AND DUTIES OF SUBCOMMITTEES:

A. The chairman shall appoint from the membership of the committee and the division any necessary subcommittees to serve for a period not exceeding the chairman's term of office.

B. The chairman shall specify the duties of such subcommittees as he may create.

[12.21.2.14 NMAC - N, 7/31/08]

HISTORY OF 12.21.2 NMAC: [RESERVED]

NEW MEXICO NAPRAPATHIC PRACTICE BOARD

This is an amendment to 16.6.1 NMAC, Section 9, effective July 31, 2008.

16.6.1.9 ORGANIZATION:

A. The naprapathic practice board is created and administratively attached to the department.

B. The board shall annually elect a president, vice president, and secretary-treasurer who shall be chosen among its members. Each officer shall hold office until his or her successors have been duly elected and qualified.

C. The board shall consist of five (5) members, three of which must be licensed naprapaths in the state of New Mexico. The governor shall appoint the members for four (4) year terms. No member shall serve more than two (2) terms, except that a person who is appointed to complete an un-expired term of a member of the board may also serve two (2) full terms.

(1) No board member shall be the owner, principal or director of an institute offering educational programs in naprapathy:

(a) a faculty member at an institute offering educational programs in naprapathy;

(b) a tutor in naprapathy; or

(c) an officer or director in a professional association of naprapathy.

(2) Paragraph (1) of this subsection shall become effective January 1, 2010.

D. **Meetings:** The board shall meet at least two (2) times per year for the purpose of transacting such business as may lawfully come before the board. Times and places of the meetings will be established by the board and advertised prior to the meetings. Three members shall conduct a quorum. Meetings will be conducted in compliance with the annual notice requirements adopted by the board.

E. **Committees:** The presiding officer at any meeting of the board is authorized to appoint special and standing committees from the membership and board approved licensees of the board. The duties of such committees shall be assigned at the time the committee is appointed.

[16.6.1.9 NMAC - N, 09-30-04; A, 07-31-08]

NEW MEXICO NAPRAPATHIC PRACTICE BOARD

This is an amendment to 16.6.3 NMAC, Section 8, effective July 31, 2008.

16.6.3.8 FEES: All fees payable to the board are non-refundable.

A. **PROCESSING FEE:** [~~An applicant for licensure may request an application packet from the board. The application must be accompanied by seventy-five dollars ($75.00) non-refundable fee.~~] $75.00. The board may assess a processing fee for administrative processing of applications.

B. **INITIAL LICENSURE FEE:** $500.00. The initial [~~certificate of~~] licensure fee shall be five hundred dollars ($500.00) in addition to the processing fee.

C. **RENEWAL FEE:** $500.00. The renewal fee shall be five hundred dollars ($500.00) annually due no later than July 1st of each year. In the event that a licensee fails to renew [~~his/her~~] their license by the deadline of any year, the board is required to assess a late fee. If an initial license is granted on or after April 1st of any year but before the license expiration date of June 30th the license will be good until the following year and the licensee will not be required to pay the renewal fee for the first year.

D. **LATE [~~FEE~~] FEES:**

(1) $100.00 to 300.00. If a renewal is post-marked past the deadline of July 1st, the board is required to charge a late fee [~~of one hundred dollars ($100.00). If a licensee fails to renew within 90 days from the expiration date he/she must pay a three hundred dollar ($300.00) late fee, submit a new application accompanied by the processing fee and reinstatement fee~~].

(a) $100.00. Late fee after July 1 through August 1

(b) $200.00. Late fee after August 1 thru September 1

(c) $300.00. Late fee after September 1 through October 1

(2) If a licensee renews their license by October 1, they must submit a renewal application accompanied by the fee and late fee. If the licensee fails to renew their license by October 1 the licensee must reinstate their license as set forth in the reinstatement procedures of the board.

E. **INACTIVE STATUS FEE:** $100.00. A licensee may submit a request in writing to the board office to be placed on inactive status. The fee for inactive status is one hundred dollars ($100.00) annually. Once a license is placed on inactive status, the licensee cannot practice naprapathy in New Mexico.

F. **REACTIVATION FROM INACTIVE STATUS:** $50.00. If the inactive licensee requests reactivation from inactive status to active status, [~~he/she~~] the licensee must complete an application for reactivation form provided by the board. The licensee will be required to pay the renewal fee. The applicant may be required to re-take the national examination at the discretion of the board.

G. **REINSTATEMENT FEE:** $500.00. If the expired licensee requests to reinstate [~~his/her~~] their license, [~~he/she~~] the licensee will be required to pay a five hundred dollar ($500.00) reinstatement fee, submit a [~~new~~] reinstatement application accompanied by the processing fee and [~~initial licensure~~] renewal fee. The applicant may be required to re-take the national examination at the discretion of the board.

H. **DUPLICATE LICENSE:** $50.00. The fee for a duplicate of original certificate of licensure to replace a lost certificate of licensure, or a replacement certificate of licensure with a new name, or for a board verified copy of certificate of licensure shall be fifty dollars ($50.00).

I. **OTHER MISCELANEOUS CHARGES:**

(1) license list $75.00
(2) license labels $100.00
(3) list/labels for commercial use $150.00
(4) copying; records request [~~$ .30~~] $ .50 per page
(5) copying; over and undersize copies $1.00 per page
(6) rules and regulations $10.00
(7) continuing education provider fee $75.00

[16.6.3.8 NMAC - N, 09-30-04; A, 07-31-08]

NEW MEXICO NAPRAPATHIC PRACTICE BOARD

This is an amendment to 16.6.4 NMAC, Section 8, effective July 31, 2008.

16.6.4.8 LICENSE EXPIRATION AND RENEWAL:

A. **License renewal:** Each licensee shall renew his/her license annually, postmarked on or before on or before July 1st of every year by remitting to the board office a renewal fee[~~of five hundred dollars ($500.00)~~] as set forth in Subsection C of 16.6.3.8 NMAC with the renewal application form provided by the board. Continuing education hours shall be documented yearly and submitted with renewal application form.

B. **Licensee responsibility:** Renewal application notices will be mailed to the last known address on file with the board office. It is the responsibility of the licensee to keep the board informed of any changes in address or phone numbers. Failure to receive the application notice shall not relieve the licensee of the responsibility of renewing [~~his/her~~] their license(s) before the expiration date.

C. **Late renewal after July 1st:** [~~The board will allow no more than thirty (30) days after license has expired to pay late fee.~~

~~(1) A license that has been expired more than thirty days, but less than 90, must pay a three hundred dollar ($300.00) late fee.~~

~~(2) A license that has been expired for over 90 days, must submit a new application, pay processing fee, late charge for expired license fee, as well as a reinstatement fee.~~] The licensee must pay a late fee as set forth in Subsection D of 16.6.3.8 NMAC. If a licensee renews their license by October 1st., they must submit a renewal application accompanied by the renewal fee and the late fee.

D. **Late renewal after October 1st:** The licensee must reinstate the license. If the licensee fails to renew their license by October 1st. the licensee must reinstate their license as set forth in the reinstatement procedures of the board.

[16.6.4.8 NMAC - N, 09-30-04; A, 07-31-08]

NEW MEXICO PUBLIC REGULATION COMMISSION

INSURANCE DIVISION

Explanatory paragraphs: This is an amendment to 13.14.18 NMAC. Sections 13, 14, 15, 19, 25, and 26 have been amended but have not been renumbered; Sections 27, 31, 32, 41, 46, 47, 70, 77 and 79 have had new material placed in them; Sections 28, 29, 30, 36, 37, 40, 45, 48, 49, 54, 67, 69, 74, 76, 78, 80, 82, 85, 86, 87, and 88 are those sections that have been renumbered and amended; Sections 33, 34, 35, 38, 39, 42, 43, 44, 50, 51, 52, 53, 55-59 (reserved/renumbered), 60, 61, 62, 63, 64, 65, 66, 68, 71, 72, 73, 75, 81, 83, 84, and 89 were renumbered from previous numbering but contain no changes to the text, all changes effective August 1, 2008. Minor stylistic and formatting changes were made throughout these sections.

Sections 19, 27, 31, 32, 41, 46, 47, 70, 77, and 79 of the renumbered rule contain newly adopted ALTA forms. Many sections were renumbered in the renumbered rule to incorporate the new sections. Ellipses ([. . . .]) indicate material in the rule that was not amended or material in which the changes have already been described in these explanatory paragraphs.

All of the material in Sections 14, 15, 37 (now Section 40 of the renumbered rule), 41 (now Section 45 of the renumbered rule), and 71 (now Section 80 of the renumbered rule) was stricken and replaced with the new material shown below.

The last paragraphs of Sections 25, 26, 27 (now Section 28 of the renumbered rule), 28 (now Section 29), 29 (now Section 30), 33 (now Section 36), Section 34 (now Section 37), 42 (now Section 48), 43 (now Section 49), 61 (now Section 67), 63 (now Section 69), 69 (now Section 76), 70 (now Section 78), Section 73 (now Section 82), 77 (now Section 86), and 78 (now Section 87) were stricken and replaced with the following language:

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Section 13 was amended and is published in its entirety to show the addition of ten new approved forms, amendments to the titles of several existing forms, the renumbering of many of the rule sections to incorporate the additional forms, and to reflect the most recent revision date of the forms.

Amendments, additions, and renumbering of affected sections as specified in 13.14.18 NMAC are effective 8-1-08.

13.14.18.13 APPROVED FORMS: The following are the only title insurance forms promulgated for use in New Mexico:

NM FORM NO.	ALTA FORM NO. & DATE	NAME OF FORM	NMAC NO.
1	[~~10-17-92~~]6-17-06	Owner's Policy	13.14.18.14
2	[~~10-17-92~~]6-17-06	Loan Policy	13.14.18.15
3	10-17-92	Construction Loan Policy	13.14.18.16
6	6-17-06	Commitment for Title Insurance	13.14.18.19
6.1	6-17-06	Plain Language Commitment for Title Insurance	13.14.18.19
7	1963	U.S. Policy	13.14.18.20
8	3-27-87	Closing Protection Letter	13.14.18.21
9		Notice of Availability of Owner's Title Insurance	13.14.18.22
10	9-24-94	Facultative Reinsurance Agreement	13.14.18.23
11		Multipurpose Endorsement	13.14.18.24
12	[~~4, Rev. 6-1-87~~]4-06, 6-17-06	Condominium (Lender's Policy) Endorsement	13.14.18.25
13	[~~5, Rev. 6-1-87~~]5-06, 6-17-06	P.U.D. Endorsement (Loan Policy)	13.14.18.26
13.1	5.1-06, 6-17-06	P.U.D. Endorsement (Owner's Policy)	13.14.18.27
14	[~~6, Rev. 6-1-87~~]6-06, 6-17-06	[~~V.R.M~~]Variable Rate, Negative Amortization Endorsement	[~~13.14.18.27~~]13.14.18.28
15	[~~6.2, Rev. 6-1-87~~]6.2-06, 6-17-06	[~~V.R.M. Endorsement,~~]Variable Rate, Negative Amortization Endorsement	[~~13.14.18.28~~]13.14.18.29
16	[~~7, Rev. 6-1-87~~]7-06, 6-17-06	Manufactured Housing Unit Endorsement	[~~13.14.18.29~~]13.14.18.30
16.1	7.1-06, 6-17-06	Manufactured Housing Conversion (Loan) Endorsement	13.14.18.31
16.2	7.2-06, 6-17-06	Manufactured Housing Conversion (Owner's) Endorsement	13.14.18.32
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18	A, Rev. 6-1-87	Construction Loan Policy Endorsement A	[~~13.14.18.31~~]13.14.18.34
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20	13-06, 6-17-06	Leasehold Owner's Endorsement	[~~13.14.18.33~~]13.14.18.36
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29	[8.1, Rev. 3-27-87] 8.1-06, 6-17-06	Environmental Protection Lien Endorsement	[13.14.18.42]13.14.18.48
30	4.1-06, 6-17-06	Condominium [Endorsement to] (Owner's Policy) Endorsement	[13.14.18.43]13.14.18.49
31		Owner's Leasehold Conversion Endorsement	[13.14.18.44]13.14.18.50
32		Coordinate and Proportionate Endorsement	[13.14.18.45]13.14.18.51
33		Change of Name Endorsement	[13.14.18.46]13.14.18.52
34	1991	U.S. Policy	[13.14.18.47]13.14.18.53
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44		Revolving Credit, Increased Credit Limit Endorsement	[13.14.18.57]13.14.18.63
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48	[Form] 2-06, 6-17-06	Truth-in-Lending Endorsement	[13.14.18.61]13.14.18.67
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58	20-06, 6-17-06	First Loss - Multiple Parcel Transactions Endorsement	[13.14.18.71]13.14.18.80
59		Last Dollar Endorsement	[13.14.18.72]13.14.18.81
60	[Form 12] 12-06, 6-17-06	[Loan Policy] Aggregatio n Endorsement	[13.14.18.73]13.14.18.82
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62		Assignment of Rents/Leases Endorsement	[13.14.18.75]13.14.18.84
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64	[ALTA 3.0, Rev. 10-17-98] 3-06, Rev. 6-17-06	Zoning [Endorsement,]- Unimproved Land Endorsement	[13.14.18.77]13.14.18.86
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[6-16-86...4-1-96; 6-1-97, 6-1-98; 13.14.18.13 NMAC - Rn, 13 NMAC 14.2.9 & A, 5-15-00; 13.14.18.13 NMAC - A, 8-1-01; A, 3-1-02; A, 7-1-03; A, 7-1-04; A, 7-1-05; A, 7-1-06; A, 8-1-08]

13.14.18.14 NM FORM 1 - OWNER'S POLICY:

Cover page.

Owner's Policy Of Title Insurance
Issued By Blank Title Insurance Company
[NM Form 1; ALTA Form Rev. 2006]

Any notice of claim and any other notice or statement in writing required to be given to the Company under this Policy must be given to the Company at the address shown in Section 18 of the Conditions.

COVERED RISKS

SUBJECT TO THE EXCLUSIONS FROM COVERAGE, THE EXCEPTIONS FROM COVERAGE CONTAINED IN SCHEDULE B, AND THE CONDITIONS [ ], BLANK TITLE INSURANCE COMPANY, a Blank corporation (the "Company") insures, as of Date of Policy and, to the extent stated in Covered Risks 9 and 10, after Date of Policy, against loss or damage, not exceeding the Amount of Insurance, sustained or incurred by the Insured by reason of:

1. Title being vested other than as stated in Schedule A.

2. Any defect in or lien or encumbrance on the Title. This Covered Risk includes but is not limited to insurance against loss from

(a) A defect in the Title caused by

(i) forgery, fraud, undue influence, duress, incompetency, incapacity, or impersonation;

(ii) failure of any person or Entity to have authorized a transfer or conveyance;

(iii) a document affecting Title not properly created, executed, witnessed, sealed, acknowledged, notarized, or delivered;

(iv) failure to perform those acts necessary to create a document by electronic means authorized by law;

(v) a document executed under a falsified, expired, or otherwise invalid power of attorney;

(vi) a document not properly filed, recorded, or indexed in the Public Records including failure to perform those acts by electronic means authorized by law; or

(vii) a defective judicial or administrative proceeding.

(b) The lien of real estate taxes or assessments imposed on the Title by a governmental authority due or payable, but unpaid.

(c) Any encroachment, encumbrance, violation, variation, or adverse circumstance affecting the Title that would be disclosed by an accurate and complete land survey of the Land. The term "encroachment" includes encroachments of existing improvements located on the Land onto adjoining land, and encroachments onto the Land of existing improvements located on adjoining land.

3. Unmarketable Title.

4. No right of access to and from the Land.

5. The violation or enforcement of any law, ordinance, permit, or governmental regulation (including those relating to building and zoning) restricting, regulating, prohibiting, or relating to

(a) the occupancy, use, or enjoyment of the Land;

(b) the character, dimensions, or location of any improvement erected on the Land;

(c) the subdivision of land; or

(d) environmental protection if a notice, describing any part of the Land, is recorded in the Public Records setting forth the violation or intention to enforce, but only to the extent of the violation or enforcement referred to in that notice.

6. An enforcement action based on the exercise of a governmental police power not covered by Covered Risk 5 if a notice of the enforcement action, describing any part of the Land, is recorded in the Public Records, but only to the extent of the enforcement referred to in that notice.

7. The exercise of the rights of eminent domain if a notice of the exercise, describing any part of the Land, is recorded in the Public Records.

8. Any taking by a governmental body that has occurred and is binding on the rights of a purchaser for value without Knowledge.

9. Title being vested other than as stated in Schedule A or being defective

(a) as a result of the avoidance in whole or in part, or from a court order providing an alternative remedy, of a transfer of all or any part of the title to or any interest in the Land occurring prior to the transaction vesting Title as shown in Schedule A because that prior transfer constituted a fraudulent or preferential transfer under federal bankruptcy, state insolvency, or similar creditors' rights laws; or

(b) because the instrument of transfer vesting Title as shown in Schedule A constitutes a preferential transfer under federal bankruptcy, state insolvency, or similar creditors' rights laws by reason of the failure of its recording in the Public Records

(i) to be timely, or
(ii) to impart notice of its existence to a purchaser for value or to a judgment or lien creditor.

10. Any defect in or lien or encumbrance on the Title or other matter included in Covered Risks 1 through 9 that has been created or attached or has been filed or recorded in the Public Records subsequent to Date of Policy and prior to the recording of the deed or other instrument of transfer in the Public Records that vests Title as shown in Schedule A.

The Company will also pay the costs, attorneys' fees, and expenses incurred in defense of any matter insured against by this Policy, but only to the extent provided in the Conditions.

[Witness clause optional]

Dated: ______________

BLANK TITLE INSURANCE COMPANY

____________________________, President

____________________________, Secretary

EXCLUSIONS FROM COVERAGE

The following matters are expressly excluded from the coverage of this policy, and the Company will not pay loss or damage, costs, attorneys' fees, or expenses that arise by reason of:

1. (a) Any law, ordinance, permit, or governmental regulation (including those relating to building and zoning) restricting, regulating, prohibiting, or relating to

(i) the occupancy, use, or enjoyment of the Land;

(ii) the character, dimensions, or location of any improvement erected on the Land;

(iii) the subdivision of land; or

(iv) environmental protection;

or the effect of any violation of these laws, ordinances, or governmental regulations. This Exclusion 1(a) does not modify or limit the coverage provided under Covered Risk 5.

(b) Any governmental police power. This Exclusion 1(b) does not modify or limit the coverage provided under Covered Risk 6.

2. Rights of eminent domain. This Exclusion does not modify or limit the coverage provided under Covered Risk 7 or 8.

3. Defects, liens, encumbrances, adverse claims, or other matters

(a) created, suffered, assumed, or agreed to by the Insured Claimant;

(b) not Known to the Company, not recorded in the Public Records at Date of Policy, but Known to the Insured Claimant and not disclosed in writing to the Company by the Insured Claimant prior to the date the Insured Claimant became an Insured under this policy;

(c) resulting in no loss or damage to the Insured Claimant;

(d) attaching or created subsequent to Date of Policy (however, this does not modify or limit the coverage provided under Covered Risk 9 and 10); or

(e) resulting in loss or damage that would not have been sustained if the Insured Claimant had paid value for the Title.

4. Any claim, by reason of the operation of federal bankruptcy, state insolvency, or similar creditors' rights laws, that the transaction vesting the Title as shown in Schedule A, is

(a) a fraudulent conveyance or fraudulent transfer; or

(b) a preferential transfer for any reason not stated in Covered Risk 9 of this policy.

5. Any lien on the Title for real estate taxes or assessments imposed by governmental authority and created or attaching between Date of Policy and the date of recording of the deed or other instrument of transfer in the Public Records that vests Title as shown in Schedule A.

SCHEDULE A

Name and Address of Title Insurance Company:

[File No.:] Policy No.:
Address Reference:
Amount of Insurance: $ [Premium: $]
Date of Policy: [at a.m./p.m.]

1. Name of Insured:

2. The estate or interest in the Land that is insured by this policy is:

3. Title is vested in:

4. The Land referred to in this policy is described as follows:

SCHEDULE B

[File No.] Policy No.

EXCEPTIONS FROM COVERAGE

This policy does not insure against loss or damage, and the Company will not pay costs, attorneys' fees, or expenses that arise by reason of:

1. [Policy may include regional exceptions if so desired by the issuing Company.]

2. [Variable exceptions such as taxes, easements, CC&R's, etc., shown here]

3.

CONDITIONS

1. DEFINITION OF TERMS

The following terms when used in this policy mean:

(a) "Amount of Insurance": The amount stated in Schedule A, as may be increased or decreased by endorsement to this policy, increased by Section 8(b), or decreased by Sections 11 and 12 of these Conditions.

(b) "Date of Policy": The date designated as "Date of Policy" in Schedule A.

(c) "Entity": A corporation, partnership, trust, limited liability company, or other similar legal entity.

(d) "Insured": The Insured named in Schedule A.

(i) The term "Insured" also includes

(A) successors to the Title of the Insured by operation of law as distinguished from purchase, including heirs, devisees, survivors, personal representatives, or next of kin;
(B) successors to an Insured by dissolution, merger, consolidation, distribution, or reorganization;
(C) successors to an Insured by its conversion to another kind of Entity;
(D) a grantee of an Insured under a deed delivered without payment of actual valuable consideration conveying the Title

(1) if the stock, shares, memberships, or other equity interests of the grantee are wholly-owned by the named Insured,
(2) if the grantee wholly owns the named Insured,
(3) if the grantee is wholly-owned by an affiliated Entity of the named Insured, provided the affiliated Entity and the named Insured are both wholly-owned by the same person or Entity, or
(4) if the grantee is a trustee or beneficiary of a trust created by a written instrument established by the Insured named in Schedule A for estate planning purposes.

(ii) With regard to (A), (B), (C), and (D) reserving, however, all rights and defenses as to any successor that the Company would have had against any predecessor Insured.

(e) "Insured Claimant": An Insured claiming loss or damage.

(f) "Knowledge" or "Known": Actual knowledge, not constructive knowledge or notice that may be imputed to an Insured by reason of the Public Records or any other records that impart constructive notice of matters affecting the Title.

(g) "Land": The land described in Schedule A, and affixed improvements that by law constitute real property. The term "Land" does not include any property beyond the lines of the area described in Schedule A, nor any right, title, interest, estate, or easement in abutting streets, roads, avenues, alleys, lanes, ways, or waterways, but this does not modify or limit the extent that a right of access to and from the Land is insured by this policy.

(h) "Mortgage": Mortgage, deed of trust, trust deed, or other security instrument, including one evidenced by electronic means authorized by law.

(i) "Public Records": Records established under state statutes at Date of Policy for the purpose of imparting constructive notice of matters relating to real property to purchasers for value and without Knowledge. With respect to Covered Risk 5(d), "Public Records" shall also include environmental protection liens filed in the records of the clerk of the United States District Court for the district where the Land is located.

(j) "Title": The estate or interest described in Schedule A.

(k) "Unmarketable Title": Title affected by an alleged or apparent matter that would permit a prospective purchaser or lessee of the Title or lender on the Title to be released from the obligation to purchase, lease, or lend if there is a contractual condition requiring the delivery of marketable title.

2. CONTINUATION OF INSURANCE

The coverage of this policy shall continue in force as of Date of Policy in favor of an Insured, but only so long as the Insured retains an estate or interest in the Land, or holds an obligation secured by a purchase money Mortgage given by a purchaser from the Insured, or only so long as the Insured shall have liability by reason of warranties in any transfer or conveyance of the Title. This policy shall not continue in force in favor of any purchaser from the Insured of either (i) an estate or interest in the Land, or (ii) an obligation secured by a purchase money Mortgage given to the Insured.

3. NOTICE OF CLAIM TO BE GIVEN BY INSURED CLAIMANT

The Insured shall notify the Company promptly in writing (i) in case of any litigation as set forth in Section 5(a) of these Conditions, (ii) in case Knowledge shall come to an Insured hereunder of any claim of title or interest that is adverse to the Title, as insured, and that might cause loss or damage for which the Company may be liable by virtue of this policy, or (iii) if the Title, as insured, is rejected as Unmarketable Title. If the Company is prejudiced by the failure of the Insured Claimant to provide prompt notice, the Company's liability to the Insured Claimant under the policy shall be reduced to the extent of the prejudice.

4. PROOF OF LOSS

In the event the Company is unable to determine the amount of loss or damage, the Company may, at its option, require as a condition of payment that the Insured Claimant furnish a signed proof of loss. The proof of loss must describe the defect, lien, encumbrance, or other matter insured against by this policy that constitutes the basis of loss or damage and shall state, to the extent possible, the basis of calculating the amount of the loss or damage.

5. DEFENSE AND PROSECUTION OF ACTIONS

(a) Upon written request by the Insured, and subject to the options contained in Section 7 of these Conditions, the Company, at its own cost and without unreasonable delay, shall provide for the defense of an Insured in litigation in which any third party asserts a claim covered by this policy adverse to the Insured. This obligation is limited to only those stated causes of action alleging matters insured against by this policy. The Company shall have the right to select counsel of its choice (subject to the right of the Insured to object for reasonable cause) to represent the Insured as to those stated causes of action. It shall not be liable for and will not pay the fees of any other counsel. The Company will not pay any fees, costs, or expenses incurred by the Insured in the defense of those causes of action that allege matters not insured against by this policy.

(b) The Company shall have the right, in addition to the options contained in Section 7 of these Conditions, at its own cost, to institute and prosecute any action or proceeding or to do any other act that in its opinion may be necessary or desirable to establish the Title, as insured, or to prevent or reduce loss or damage to the Insured. The Company may take any appropriate action under the terms of this policy, whether or not it shall be liable to the Insured. The exercise of these rights shall not be an admission of liability or waiver of any provision of this policy. If the Company exercises its rights under this subsection, it must do so diligently.

(c) Whenever the Company brings an action or asserts a defense as required or permitted by this policy, the Company may pursue the litigation to a final determination by a court of competent jurisdiction, and it expressly reserves the right, in its sole discretion, to appeal any adverse judgment or order.

6. DUTY OF INSURED CLAIMANT TO COOPERATE

(a) In all cases where this policy permits or requires the Company to prosecute or provide for the defense of any action or proceeding and any appeals, the Insured shall secure to the Company the right to so prosecute or provide defense in the action or proceeding, including the right to use, at its option, the name of the Insured for this purpose. Whenever requested by the Company, the Insured, at the Company's expense, shall give the Company all reasonable aid (i) in securing evidence, obtaining witnesses, prosecuting or defending the action or proceeding, or effecting settlement, and (ii) in any other lawful act that in the opinion of the Company may be necessary or desirable to establish the Title or any other matter as insured. If the Company is prejudiced by the failure of the Insured to furnish the required cooperation, the Company's obligations to the Insured under the policy shall terminate, including any liability or obligation to defend, prosecute, or continue any litigation, with regard to the matter or matters requiring such cooperation.

(b) The Company may reasonably require the Insured Claimant to submit to examination under oath by any authorized representative of the Company and to produce for examination, inspection, and copying, at such reasonable times and places as may be designated by the authorized representative of the Company, all records, in whatever medium maintained, including books, ledgers, checks, memoranda, correspondence, reports, e-mails, disks, tapes, and videos whether bearing a date before or after Date of Policy, that reasonably pertain to the loss or damage. Further, if requested by any authorized representative of the Company, the Insured Claimant shall grant its permission, in writing, for any authorized representative of the Company to examine, inspect, and copy all of these records in the custody or control of a third party that reasonably pertain to the loss or damage. All information designated as confidential by the Insured Claimant provided to the Company pursuant to this Section shall not be disclosed to others unless, in the reasonable judgment of the Company, it is necessary in the administration of the claim. Failure of the Insured Claimant to submit for examination under oath, produce any reasonably requested information, or grant permission to secure reasonably necessary information from third parties as required in this subsection, unless prohibited by law or governmental regulation, shall terminate any liability of the Company under this policy as to that claim.

7. OPTIONS TO PAY OR OTHERWISE SETTLE CLAIMS; TERMINATION OF LIABILITY

In case of a claim under this policy, the Company shall have the following additional options:

(a) To Pay or Tender Payment of the Amount of Insurance.

To pay or tender payment of the Amount of Insurance under this policy together with any costs, attorneys' fees, and expenses incurred by the Insured Claimant that were authorized by the Company up to the time of payment or tender of payment and that the Company is obligated to pay.

Upon the exercise by the Company of this option, all liability and obligations of the Company to the Insured under this policy, other than to make the payment required in this subsection, shall terminate, including any liability or obligation to defend, prosecute, or continue any litigation.

(b) To Pay or Otherwise Settle With Parties Other Than the Insured or With the Insured Claimant.

(i) To pay or otherwise settle with other parties for or in the name of an Insured Claimant any claim insured against under this policy. In addition, the Company will pay any costs, attorneys' fees, and expenses incurred by the Insured Claimant that were authorized by the Company up to the time of payment and that the Company is obligated to pay; or

(ii) To pay or otherwise settle with the Insured Claimant the loss or damage provided for under this policy, together with any costs, attorneys' fees, and expenses incurred by the Insured Claimant that were authorized by the Company up to the time of payment and that the Company is obligated to pay.

Upon the exercise by the Company of either of the options provided for in subsections (b)(i) or (ii), the Company's obligations to the Insured under this policy for the claimed loss or damage, other than the payments required to be made, shall terminate, including any liability or obligation to defend, prosecute, or continue any litigation.

8. DETERMINATION AND EXTENT OF LIABILITY

This policy is a contract of indemnity against actual monetary loss or damage sustained or incurred by the Insured Claimant who has suffered loss or damage by reason of matters insured against by this policy.

(a) The extent of liability of the Company for loss or damage under this policy shall not exceed the lesser of

(i) the Amount of Insurance; or

(ii) the difference between the value of the Title as insured and the value of the Title subject to the risk insured against by this policy.

(b) If the Company pursues its rights under Section 5 of these Conditions and is unsuccessful in establishing the Title, as insured,

(i) the Amount of Insurance shall be increased by 10%, and

(ii) the Insured Claimant shall have the right to have the loss or damage determined either as of the date the claim was made by the Insured Claimant or as of the date it is settled and paid.

(c) In addition to the extent of liability under (a) and (b), the Company will also pay those costs, attorneys' fees, and expenses incurred in accordance with Sections 5 and 7 of these Conditions.

9. LIMITATION OF LIABILITY

(a) If the Company establishes the Title, or removes the alleged defect, lien, or encumbrance, or cures the lack of a right of access to or from the Land, or cures the claim of Unmarketable Title, all as insured, in a reasonably diligent manner by any method, including litigation and the completion of any appeals, it shall have fully performed its obligations with respect to that matter and shall not be liable for any loss or damage caused to the Insured.

(b) In the event of any litigation, including litigation by the Company or with the Company's consent, the Company shall have no liability for loss or damage until there has been a final determination by a court of competent jurisdiction, and disposition of all appeals, adverse to the Title, as insured.

(c) The Company shall not be liable for loss or damage to the Insured for liability voluntarily assumed by the Insured in settling any claim or suit without the prior written consent of the Company.

10. REDUCTION OF INSURANCE; REDUCTION OR TERMINATION OF LIABILITY

All payments under this policy, except payments made for costs, attorneys' fees, and expenses, shall reduce the Amount of Insurance by the amount of the payment.

11. LIABILITY NONCUMULATIVE

The Amount of Insurance shall be reduced by any amount the Company pays under any policy insuring a Mortgage to which exception is taken in Schedule B or to which the Insured has agreed, assumed, or taken subject, or which is executed by an Insured after Date of Policy and which is a charge or lien on the Title, and the amount so paid shall be deemed a payment to the Insured under this policy.

12. PAYMENT OF LOSS

When liability and the extent of loss or damage have been definitely fixed in accordance with these Conditions, the payment shall be made within 30 days.

13. RIGHTS OF RECOVERY UPON PAYMENT OR SETTLEMENT

(a) Whenever the Company shall have settled and paid a claim under this policy, it shall be subrogated and entitled to the rights of the Insured Claimant in the Title and all other rights and remedies in respect to the claim that the Insured Claimant has against any person or property, to the extent of the amount of any loss, costs, attorneys' fees, and expenses paid by the Company. If requested by the Company, the Insured Claimant shall execute documents to evidence the transfer to the Company of these rights and remedies. The Insured Claimant shall permit the Company to sue, compromise, or settle in the name of the Insured Claimant and to use the name of the Insured Claimant in any transaction or litigation involving these rights and remedies.

If a payment on account of a claim does not fully cover the loss of the Insured Claimant, the Company shall defer the exercise of its right to recover until after the Insured Claimant shall have recovered its loss.

(b) The Company's right of subrogation includes the rights of the Insured to indemnities, guaranties, other policies of insurance, or bonds, notwithstanding any terms or conditions contained in those instruments that address subrogation rights.

14. ARBITRATION

Either the Company or the Insured may demand that the claim or controversy shall be submitted to arbitration pursuant to the Title Insurance Arbitration Rules of the American Land Title Association ("Rules"). Except as provided in the Rules, there shall be no joinder or consolidation with claims or controversies of other persons. Arbitrable matters may include, but are not limited to, any controversy or claim between the Company and the Insured arising out of or relating to this policy, any service in connection with its issuance or the breach of

a policy provision, or to any other controversy or claim arising out of the transaction giving rise to this policy. All arbitrable matters when the Amount of Insurance is $2,000,000 or less shall be arbitrated at the option of either the Company or the Insured. All arbitrable matters when the Amount of Insurance is in excess of $2,000,000 shall be arbitrated only when agreed to by both the Company and the Insured. Arbitration pursuant to this policy and under the Rules shall be binding upon the parties. Judgment upon the award rendered by the Arbitrator(s) may be entered in any court of competent jurisdiction.

15. LIABILITY LIMITED TO THIS POLICY; POLICY ENTIRE CONTRACT

(a) This policy together with all endorsements, if any, attached to it by the Company is the entire policy and contract between the Insured and the Company. In interpreting any provision of this policy, this policy shall be construed as a whole.

(b) Any claim of loss or damage that arises out of the status of the Title or by any action asserting such claim shall be restricted to this policy.

(c) Any amendment of or endorsement to this policy must be in writing and authenticated by an authorized person, or expressly incorporated by Schedule A of this policy.

(d) Each endorsement to this policy issued at any time is made a part of this policy and is subject to all of its terms and provisions. Except as the endorsement expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsement, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance.

16. SEVERABILITY

In the event any provision of this policy, in whole or in part, is held invalid or unenforceable under applicable law, the policy shall be deemed not to include that provision or such part held to be invalid, but all other provisions shall remain in full force and effect.

17. CHOICE OF LAW; FORUM

(a) Choice of Law: The Insured acknowledges the Company has underwritten the risks covered by this policy and determined the premium charged therefor in reliance upon the law affecting interests in real property and applicable to the interpretation, rights, remedies, or enforcement of policies of title insurance of the jurisdiction where the Land is located.

Therefore, the court or an arbitrator shall apply the law of the jurisdiction where the Land is located to determine the validity of claims against the Title that are adverse to the Insured and to interpret and enforce the terms of this policy. In neither case shall the court or arbitrator apply its conflicts of law principles to determine the applicable law.

(b) Choice of Forum: Any litigation or other proceeding brought by the Insured against the Company must be filed only in a state or federal court within the United States of America or its territories having appropriate jurisdiction.

18. NOTICES, WHERE SENT

Any notice of claim and any other notice or statement in writing required to be given to the Company under this policy must be given to the Company at [fill in].

NOTE: Bracketed [ ] material optional

[6-16-86...4-3-95; 13.14.18.14 NMAC - Rn, 13 NMAC 14.6.A.8 through 14.6.A.12, 5-15-00; A, 8-1-08]

13.14.18.15 NM FORM 2 - LOAN POLICY:

Cover page.

Loan Policy Of Title Insurance
Issued By Blank Title Insurance Company
[NM Form 2; ALTA Form Rev. 2006]

Any notice of claim and any other notice or statement in writing required to be given to the Company under this Policy must be given to the Company at the address shown in Section 17 of the Conditions.

Covered risks.

SUBJECT TO THE EXCLUSIONS FROM COVERAGE, THE EXCEPTIONS FROM COVERAGE CONTAINED IN SCHEDULE B, AND THE CONDITIONS, BLANK TITLE INSURANCE COMPANY, a Blank corporation (the “Company”) insures as of Date of Policy and, to the extent stated in Covered Risks 11, 13, and 14, after Date of Policy, against loss or damage, not exceeding the Amount of Insurance, sustained or incurred by the Insured by reason of:

1. Title being vested other than as stated in Schedule A.

2. Any defect in or lien or encumbrance on the Title. This Covered Risk includes but is not limited to insurance against loss from

(a) A defect in the Title caused by

(i) forgery, fraud, undue influence, duress, incompetency, incapacity, or impersonation;

(ii) failure of any person or Entity to have authorized a transfer or conveyance;

(iii) a document affecting Title not properly created, executed, witnessed, sealed, acknowledged, notarized, or delivered;

(iv) failure to perform those acts necessary to create a document by electronic means authorized by law;

(v) a document executed under a falsified, expired, or otherwise invalid power of attorney;

(vi) a document not properly filed, recorded, or indexed in the Public Records including failure to perform those acts by electronic means authorized by law; or

(vii) a defective judicial or administrative proceeding.

(b) The lien of real estate taxes or assessments imposed on the Title by a governmental authority due or payable, but unpaid.

(c) Any encroachment, encumbrance, violation, variation, or adverse circumstance affecting the Title that would be disclosed by an accurate and complete land survey of the Land. The term "encroachment" includes encroachments of existing improvements located on the Land onto adjoining land, and encroachments onto the Land of existing improvements located on adjoining land.

3. Unmarketable Title.

4. No right of access to and from the Land.

5. The violation or enforcement of any law, ordinance, permit, or governmental regulation (including those relating to building and zoning) restricting, regulating, prohibiting, or relating to

(a) the occupancy, use, or enjoyment of the Land;

(b) the character, dimensions, or location of any improvement erected on the Land;

(c) the subdivision of land; or

(d) environmental protection if a notice, describing any part of the Land, is recorded in the Public Records setting forth the violation or intention to enforce, but only to the extent of the violation or enforcement referred to in that notice.

6. An enforcement action based on the exercise of a governmental police power not covered by Covered Risk 5 if a notice of the enforcement action, describing any part of the Land, is recorded in the Public Records, but only to the extent of the enforcement referred to in that notice.

7. The exercise of the rights of eminent domain if a notice of the exercise, describing any part of the Land, is recorded in the Public Records.

8. Any taking by a governmental body that has occurred and is binding on the rights of a purchaser for value without Knowledge.

9. The invalidity or unenforceability of the lien of the Insured Mortgage upon the Title. This Covered Risk includes but is not limited to insurance against loss from any of the following impairing the lien of the Insured Mortgage

(a) forgery, fraud, undue influence, duress, incompetency, incapacity, or impersonation;

(b) failure of any person or Entity to have authorized a transfer or conveyance;

(c) the Insured Mortgage not being properly created, executed, witnessed, sealed, acknowledged, notarized, or delivered;

(d) failure to perform those acts necessary to create a document by electronic means authorized by law;

(e) a document executed under a falsified, expired, or otherwise invalid power of attorney;

(f) a document not properly filed, recorded, or indexed in the Public Records including failure to perform those acts by electronic means authorized by law; or

(g) a defective judicial or administrative proceeding.

10. The lack of priority of the lien of the Insured Mortgage upon the Title over any other lien or encumbrance.

11. The lack of priority of the lien of the Insured Mortgage upon the Title

(a) as security for each and every advance of proceeds of the loan secured by the Insured Mortgage over any statutory lien for services, labor, or material arising from construction of an improvement or work related to the Land when the improvement or work is either

(i) contracted for or commenced on or before Date of Policy; or

(ii) contracted for, commenced, or continued after Date of Policy if the construction is financed, in whole or in part, by proceeds of the loan secured by the Insured Mortgage that the Insured has advanced or is obligated on Date of Policy to advance; and

(b) over the lien of any assessments for street improvements under construction or completed at Date of Policy.

12. The invalidity or unenforceability of any assignment of the Insured Mortgage, provided the assignment is shown in Schedule A, or the failure of the assignment shown in Schedule A to vest title to the Insured Mortgage in the named Insured assignee free and clear of all liens.

13. The invalidity, unenforceability, lack of priority, or avoidance of the lien of the Insured Mortgage upon the Title

(a) resulting from the avoidance in whole or in part, or from a court order providing an alternative remedy, of any transfer of all or any part of the title to or any interest in the Land occurring prior to the transaction creating the lien of the Insured Mortgage because that prior transfer constituted a fraudulent or preferential transfer under federal bankruptcy, state insolvency, or similar creditors' rights laws; or

(b) because the Insured Mortgage constitutes a preferential transfer under federal bankruptcy, state insolvency, or similar creditors' rights laws by reason of the failure of its recording in the Public Records

(i) to be timely, or

(ii) to impart notice of its existence to a purchaser for value or to a judgment or lien creditor.

14. Any defect in or lien or encumbrance on the Title or other matter included in Covered Risks 1 through 13 that has been created or attached or has been filed or recorded in the Public Records subsequent to Date of Policy and prior to the recording of the Insured Mortgage in the Public Records.

The Company will also pay the costs, attorneys' fees, and expenses incurred in defense of any matter insured against by this Policy, but only to the extent provided in the Conditions.

[Witness clause optional]

BLANK TITLE INSURANCE COMPANY

BY:____, PRESIDENT

BY:____, SECRETARY

Exclusions from coverage.

The following matters are expressly excluded from the coverage of this policy, and the Company will not pay loss or damage, costs, attorneys' fees, or expenses that arise by reason of:

1. (a) Any law, ordinance, permit, or governmental regulation (including those relating to building and zoning) restricting, regulating, prohibiting, or relating to (i) the occupancy, use, or enjoyment of the Land; (ii) the character, dimensions, or location of any improvement erected on the Land; (iii) the subdivision of land; or (iv) environmental protection; or the effect of any violation of these laws, ordinances, or governmental regulations. This Exclusion 1(a) does not modify or limit the coverage provided under Covered Risk 5.

(b) Any governmental police power. This Exclusion 1(b) does not modify or limit the coverage provided under Covered Risk 6.

2. Rights of eminent domain. This Exclusion does not modify or limit the coverage provided under Covered Risks 7 or 8.

3. Defects, liens, encumbrances, adverse claims, or other matters

(a) created, suffered, assumed, or agreed to by the Insured Claimant;

(b) not Known to the Company, not recorded in the Public Records at Date of Policy, but Known to the Insured Claimant and not disclosed

in writing to the Company by the Insured Claimant prior to the date the Insured Claimant became an Insured under this policy;

(c) resulting in no loss or damage to the Insured Claimant;

(d) attaching or created subsequent to Date of Policy (however, this does not modify or limit the coverage provided under Covered Risks 11, 13, or 14); or

(e) resulting in loss or damage that would not have been sustained if the Insured Claimant had paid value for the Insured Mortgage.

4. Unenforceability of the lien of the Insured Mortgage because of the inability or failure of an Insured to comply with applicable doing-business laws of the state where the Land is situated.

5. Invalidity or unenforceability in whole or in part of the lien of the Insured Mortgage that arises out of the transaction evidenced by the Insured Mortgage and is based upon usury or any consumer credit protection or truth-in-lending law.

6. Any claim, by reason of the operation of federal bankruptcy, state insolvency, or similar creditors' rights laws, that the transaction creating the lien of the Insured Mortgage, is

(a) a fraudulent conveyance or fraudulent transfer, or

(b) a preferential transfer for any reason not stated in Covered Risk 13(b) of this policy.

7. Any lien on the Title for real estate taxes or assessments imposed by governmental authority and created or attaching between Date of Policy and the date of recording of the Insured Mortgage in the Public Records. This Exclusion does not modify or limit the coverage provided under Covered Risk 11(b).

Schedule A.

Name and Address of Title Insurance Company:
[File No. __________]
Policy No.
Loan No.
Address Reference:
Amount of Insurance: $
[Premium: $ _________]
Date of Policy:_____________________[at a.m./p.m.]

1. Name of Insured:

2. The estate or interest in the Land that is encumbered by the Insured Mortgage is:

3. Title is vested in:

4. The Insured Mortgage and its assignments, if any, are described as follows:

5. The Land referred to in this policy is described as follows:

[6. This policy incorporates by reference those ALTA endorsements selected below:

__4-06 (Condominium)
__4.1-06
__5-06 (Planned Unit Development)
__5.1-06
__6-06 (Variable Rate)
__6.2-06 (Variable Rate—Negative Amortization)
__8.1-06 (Environmental Protection Lien) Paragraph b refers to the following state statute(s):
__9-06 (Restrictions, Encroachments, Minerals)
__13.1-06 (Leasehold Loan)

Schedule B - Exceptions from coverage.

[File No. ___]
Policy No.

[Except as provided in Schedule B - Part II,] t[or T]his policy does not insure against loss or damage, and the Company will not pay costs, attorneys' fees, or expenses that arise by reason of:

[PART I

1.

2.

3.

4.

PART II

In addition to the matters set forth in Part I of this Schedule, the Title is subject to the following matters, and the Company insures against loss or damage sustained in the event that they are not subordinate to the lien of the Insured Mortgage:]

Conditions.

1. Definition of Terms. The following terms when used in this policy mean:

(a) “Amount of Insurance”: The amount stated in Schedule A, as may be increased or decreased by endorsement to this policy, increased by Section 8(b) or decreased by Section 10 of these Conditions.

(b) “Date of Policy”: The date designated as “Date of Policy” in Schedule A.

(c) “Entity”: A corporation, partnership, trust, limited liability company, or other similar legal entity.

(d) “Indebtedness”: The obligation secured by the Insured Mortgage including one evidenced by electronic means authorized by law, and if that obligation is the payment of a debt, the Indebtedness is the sum of

(i) the amount of the principal disbursed as of Date of Policy;

(ii) the amount of the principal disbursed subsequent to Date of Policy;

(iii) the construction loan advances made subsequent to Date of Policy for the purpose of financing in whole or in part the construction of an improvement to the Land or related to the Land that the Insured was and continued to be obligated to advance at Date of Policy and at the date of the advance;

(iv) interest on the loan;

(v) the prepayment premiums, exit fees, and other similar fees or penalties allowed by law;

(vi) the expenses of foreclosure and any other costs of enforcement;

(vii) the amounts advanced to assure compliance with laws or to protect the lien or the priority of the lien of the Insured Mortgage before the acquisition of the estate or interest in the Title;

(viii) the amounts to pay taxes and insurance; and

(ix) the reasonable amounts expended to prevent deterioration of improvements; but the Indebtedness is reduced by the total of all payments and by any amount forgiven by an Insured.

(e) “Insured”: The Insured named in Schedule A.

(i) The term “Insured” also includes

(A) the owner of the Indebtedness and each successor in ownership of the Indebtedness, whether the owner or successor owns the Indebtedness for its own account or as a trustee or other fiduciary, except a successor who is an obligor under the provisions of Section 12(c) of these Conditions;

(B) the person or Entity who has “control” of the “transferable record,” if the Indebtedness is evidenced by a “transferable record,” as these terms are defined by applicable electronic transactions law;

(C) successors to an Insured by dissolution, merger, consolidation, distribution, or reorganization;

(D) successors to an Insured by its conversion to another kind of Entity;

(E) a grantee of an Insured under a deed delivered without payment of actual valuable consideration conveying the Title (1) if the stock, shares, memberships, or other equity interests of the grantee are wholly-owned by the named Insured, (2) if the grantee wholly owns the named Insured, or (3) if the grantee is wholly-owned by an affiliated Entity of the named Insured, provided the affiliated Entity and the named Insured are both wholly-owned by the same person or Entity;

(F) any government agency or instrumentality that is an insurer or guarantor under an insurance contract or guaranty insuring or guaranteeing the Indebtedness secured by the Insured Mortgage, or any part of it, whether named as an Insured or not;

(ii) With regard to (A), (B), (C), (D) , and (E) reserving, however, all rights and defenses as to any successor that the Company would have had against any predecessor Insured, unless the successor acquired the Indebtedness as a purchaser for value without Knowledge of the asserted defect, lien, encumbrance, or other matter insured against by this policy.

(f) “Insured Claimant”: An Insured claiming loss or damage.

(g) “Insured Mortgage”: The Mortgage described in paragraph 4 of Schedule A.

(h) “Knowledge” or “Known”: Actual knowledge, not constructive knowledge or notice that may be imputed to an Insured by reason of the Public Records or any other records that impart constructive notice of matters affecting the Title.

(i) “Land”: The land described in Schedule A, and affixed improvements that by law constitute real property. The term “Land” does not include any property beyond the lines of the area described in Schedule A, nor any right, title, interest, estate, or easement in abutting streets, roads, avenues, alleys, lanes, ways, or waterways, but this does not modify or limit the extent that a right of access to and from the Land is insured by this policy.

(j) “Mortgage”: Mortgage, deed of trust, trust deed, or other security instrument, including one evidenced by electronic means authorized by law.

(k) “Public Records”: Records established under state statutes at Date of Policy for the purpose of imparting constructive notice of matters relating to real property to purchasers for value and without Knowledge. With respect to Covered Risk 5(d), “Public Records” shall also include environmental protection liens filed in the records of the clerk of the United States District Court for the district where the Land is located.

(l) “Title”: The estate or interest described in Schedule A.

(m) “Unmarketable Title”: Title affected by an alleged or apparent matter that would permit a prospective purchaser or lessee of the Title or lender on the Title or a prospective purchaser of the Insured Mortgage to be released from the obligation to purchase, lease, or lend if there is a contractual condition requiring the delivery of marketable title.

2. Continuation of insurance. The coverage of this policy shall continue in force as of Date of Policy in favor of an Insured after acquisition of the Title by an Insured or after conveyance by an Insured, but only so long as the Insured retains an estate or interest in the Land, or holds an obligation secured by a purchase money Mortgage given by a purchaser from the Insured, or only so long as the Insured shall have liability by reason of warranties in any transfer or conveyance of the Title. This policy shall not continue in force in favor of any purchaser from the Insured of either (i) an estate or interest in the Land, or (ii) an obligation secured by a purchase money Mortgage given to the Insured.

3. Notice of claim to be given by insured claimant. The Insured shall notify the Company promptly in writing (i) in case of any litigation as set forth in Section 5(a) of these Conditions, (ii) in case Knowledge shall come to an Insured of any claim of title or interest that is adverse to the Title or the lien of the Insured Mortgage, as insured, and that might cause loss or damage for which the Company may be liable by virtue of this policy, or (iii) if the Title or the lien of the Insured Mortgage, as insured, is rejected as Unmarketable Title. If the Company is prejudiced by the failure of the Insured Claimant to provide prompt notice, the Company’s liability to the Insured Claimant under the policy shall be reduced to the extent of the prejudice.

4. Proof of loss. In the event the Company is unable to determine the amount of loss or damage, the Company may, at its option, require as a condition of payment that the Insured Claimant furnish a signed proof of loss. The proof of loss must describe the defect, lien, encumbrance, or other matter insured against by this policy that constitutes the basis of loss or damage and shall state, to the extent possible, the basis of calculating the amount of the loss or damage.

5. Defense and prosecution of actions.

(a) Upon written request by the Insured, and subject to the options contained in Section 7 of these Conditions, the Company, at its own cost and without unreasonable delay, shall provide for the defense of an Insured in litigation in which any third party asserts a claim covered by this policy adverse to the Insured. This obligation is limited to only those stated causes of action alleging matters insured against by this policy. The Company shall have the right to select counsel of its choice (subject to the right of the Insured to object for reasonable cause) to represent the Insured as to those stated causes of action. It shall not be liable for and will not pay the fees of any other counsel. The Company will not pay any fees, costs, or expenses incurred by the Insured in the defense of those causes of action that allege matters not insured against by this policy.

(b) The Company shall have the right, in addition to the options contained in Section 7 of these Conditions, at its own cost, to institute and prosecute any action or proceeding or to do any other act that in its opinion may be necessary or desirable to establish the Title or the lien of the Insured Mortgage, as insured, or to prevent or reduce loss or damage to the Insured. The Company may take any appropriate action under the terms of this policy, whether or not it shall be liable to the Insured. The exercise of these rights shall not be an admission of liability or waiver of any provision of this policy. If the Company exercises its rights under this subsection, it must do so diligently.

(c) Whenever the Company brings an action or asserts a defense as required or permitted by this policy, the Company may pursue the litigation to a final determination by a court of competent jurisdiction, and it expressly reserves the right, in its sole discretion, to appeal any adverse judgment or order.

6. Duty of insured claimant to cooperate.

(a) In all cases where this policy permits or requires the Company to prosecute or provide for the defense of any action or proceeding and any appeals, the Insured shall secure to the Company the right to so prosecute or provide defense in the action or proceeding, including the right to use, at its option, the name of the Insured for this purpose. Whenever requested by the Company, the Insured, at the Company's expense, shall give the Company all reasonable aid (i) in securing evidence, obtaining witnesses, prosecuting or defending the action or proceeding, or effecting settlement, and (ii) in any other lawful act that in the opinion of the Company may be necessary or desirable to establish the Title, the lien of the Insured Mortgage, or any other matter as insured. If the Company is prejudiced by the failure of the Insured to furnish the required cooperation, the Company's obligations to the Insured under the policy shall terminate, including any liability or obligation to defend, prosecute, or continue any litigation, with regard to the matter or matters requiring such cooperation.

(b) The Company may reasonably require the Insured Claimant to submit to examination under oath by any authorized representative of the Company and to produce for examination, inspection, and copying, at such reasonable times and places as may be designated by the authorized representative of the Company, all records, in whatever medium maintained, including books, ledgers, checks, memoranda, correspondence, reports, e-mails, disks, tapes, and videos whether bearing a date before or after Date of Policy, that reasonably pertain to the loss or damage. Further, if requested by any authorized representative of the Company, the Insured Claimant shall grant its permission, in writing, for any authorized representative of the Company to examine, inspect, and copy all of these records in the custody or control of a third party that reasonably pertain to the loss or damage. All information designated as confidential by the Insured Claimant provided to the Company pursuant to this Section shall not be disclosed to others unless, in the reasonable judgment of the Company, it is necessary in the administration of the claim. Failure of the Insured Claimant to submit for examination under oath, produce any reasonably requested information, or grant permission to secure reasonably necessary information from third parties as required in this subsection, unless prohibited by law or governmental regulation, shall terminate any liability of the Company under this policy as to that claim.

7. Options to pay or otherwise settle claims, termination of liability. In case of a claim under this policy, the Company shall have the following additional options:

(a) To Pay or Tender Payment of the Amount of Insurance or to Purchase the Indebtedness.

(i) To pay or tender payment of the Amount of Insurance under this policy together with any costs, attorneys' fees, and expenses incurred by the Insured Claimant that were authorized by the Company up to the time of payment or tender of payment and that the Company is obligated to pay; or

(ii) To purchase the Indebtedness for the amount of the Indebtedness on the date of purchase, together with any costs, attorneys' fees, and expenses incurred by the Insured Claimant that were authorized by the Company up to the time of purchase and that the Company is obligated to pay. When the Company purchases the Indebtedness, the Insured shall transfer, assign, and convey to the Company the Indebtedness and the Insured Mortgage, together with any collateral security. Upon the exercise by the Company of either of the options provided for in subsections (a)(i) or (ii), all liability and obligations of the Company to the Insured under this policy, other than to make the payment required in those subsections, shall terminate, including any liability or obligation to defend, prosecute, or continue any litigation.

(b) To Pay or Otherwise Settle With Parties Other Than the Insured or With the Insured Claimant.

(i) to pay or otherwise settle with other parties for or in the name of an Insured Claimant any claim insured against under this policy. In addition, the Company will pay any costs, attorneys' fees, and expenses incurred by the Insured Claimant that were authorized by the Company up to the time of payment and that the Company is obligated to pay; or

(ii) to pay or otherwise settle with the Insured Claimant the loss or damage provided for under this policy, together with any costs, attorneys' fees, and expenses incurred by the Insured Claimant that were authorized by the Company up to the time of payment and that the Company is obligated to pay.

Upon the exercise by the Company of either of the options provided for in subsections (b)(i) or (ii), the Company's obligations to the Insured under this policy for the claimed loss or damage, other than the payments required to be made, shall terminate, including any liability or obligation to defend, prosecute, or continue any litigation.

8. Determination and extent of liability. This policy is a contract of indemnity against actual monetary loss or damage sustained or incurred by the Insured Claimant who has suffered loss or damage by reason of matters insured against by this policy.

(a) The extent of liability of the Company for loss or damage under this policy shall not exceed the least of

(i) the Amount of Insurance;

(ii) the Indebtedness;

(iii) the difference between the value of the Title as insured and the value of the Title subject to the risk insured against by this policy; or

(iv) if a government agency or instrumentality is the Insured Claimant, the amount it paid in the acquisition of the Title or the Insured Mortgage in satisfaction of its insurance contract or guaranty.

(b) If the Company pursues its rights under Section 5 of these Conditions and is unsuccessful in establishing the Title or the lien of the Insured Mortgage, as insured,

(i) the Amount of Insurance shall be increased by 10%; and

(ii) the Insured Claimant shall have the right to have the loss or damage determined either as of the date the claim was made by the Insured Claimant or as of the date it is settled and paid.

(c) In the event the Insured has acquired the Title in the manner described in Section 2 of these Conditions or has conveyed the Title, then the extent of liability of the Company shall continue as set forth in Section 8(a) of these Conditions.

(d) In addition to the extent of liability under (a), (b), and (c), the Company will also pay those costs, attorneys' fees, and expenses incurred in accordance with Sections 5 and 7 of these Conditions.

9. Limitation of liability.

(a) If the Company establishes the Title, or removes the alleged defect, lien, or encumbrance, or cures the lack of a right of access to or from the Land, or cures the claim of Unmarketable Title, or establishes the lien of the Insured Mortgage, all as insured, in a reasonably diligent manner by any method, including litigation and the completion of any appeals, it shall have fully performed its obligations with respect to that matter and shall not be liable for any loss or damage caused to the Insured.

(b) In the event of any litigation, including litigation by the Company or with the Company's consent, the Company shall have no liability for loss or damage until there has been a final determination by a court of competent jurisdiction, and disposition of all appeals, adverse to the Title or to the lien of the Insured Mortgage, as insured.

(c) The Company shall not be liable for loss or damage to the Insured for liability voluntarily assumed by the Insured in settling any claim or suit without the prior written consent of the Company.

10. Reduction of insurance; reduction or termination of liability

(a) All payments under this policy, except payments made for costs, attorneys' fees, and expenses, shall reduce the Amount of Insurance by the amount of the payment. However, any payments made prior to the acquisition of Title as provided in Section 2 of these Conditions shall not reduce the Amount of Insurance afforded under this policy except to the extent that the payments reduce the Indebtedness.

(b) The voluntary satisfaction or release of the Insured Mortgage shall terminate all liability of the Company except as provided in Section 2 of these Conditions.

11. Payment of loss. When liability and the extent of loss or damage have been definitely fixed in accordance with these Conditions, the payment shall be made within 30 days.

12. Rights of recovery upon payment or settlement

(a) The Company's Right to Recover

Whenever the Company shall have settled and paid a claim under this policy, it shall be subrogated and entitled to the rights of the Insured Claimant in the Title or Insured Mortgage and all other rights and remedies in respect to the claim that the Insured Claimant has against any person or property, to the extent of the amount of any loss, costs, attorneys' fees, and expenses paid by the Company. If requested by the Company, the Insured Claimant shall execute documents to evidence the transfer to the Company of these rights and remedies. The Insured Claimant shall permit the Company to sue, compromise, or settle in the name of the Insured Claimant and to use the name of the Insured Claimant in any transaction or litigation involving these rights and remedies.

If a payment on account of a claim does not fully cover the loss of the Insured Claimant, the Company shall defer the exercise of its right to recover until after the Insured Claimant shall have recovered its loss.

(b) The Insured's Rights and Limitations

(i) The owner of the Indebtedness may release or substitute the personal liability of any debtor or guarantor, extend or otherwise modify the terms of payment, release a portion of the Title from the lien of the Insured Mortgage, or release any collateral security for the Indebtedness, if it does not affect the enforceability or priority of the lien of the Insured Mortgage.

(ii) If the Insured exercises a right provided in (b)(i), but has Knowledge of any claim adverse to the Title or the lien of the Insured Mortgage insured against by this policy, the Company shall be required to pay only that part of any losses insured against by this policy that shall exceed the amount, if any, lost to the Company by reason of the impairment by the Insured Claimant of the Company's right of subrogation.

(c) The Company's Rights Against Noninsured Obligors

The Company's right of subrogation includes the Insured's rights against non-insured obligors including the rights of the Insured to indemnities, guaranties, other policies of insurance, or bonds, notwithstanding any terms or conditions contained in those instruments that address subrogation rights.

The Company's right of subrogation shall not be avoided by acquisition of the Insured Mortgage by an obligor (except an obligor described in Section 1(e)(i)(F) of these Conditions) who acquires the Insured Mortgage as a result of an indemnity, guarantee, other policy of insurance, or bond, and the obligor will not be an Insured under this policy.

13. Arbitration. Either the Company or the Insured may demand that the claim or controversy shall be submitted to arbitration pursuant to the Title Insurance Arbitration Rules of the American Land Title Association ("Rules"). Except as provided in the Rules, there shall be no joinder or consolidation with claims or controversies of other persons. Arbitrable matters may include, but are not limited to, any controversy or claim between the Company and the Insured arising out of or relating to this policy, any service in connection with its issuance or the breach of a policy provision, or to any other controversy or claim arising out of the transaction giving rise to this policy. All arbitrable matters when the Amount of Insurance is $2,000,000 or less shall be arbitrated at the option of either the Company or the Insured. All arbitrable matters when the Amount of Insurance is in excess of $2,000,000 shall be arbitrated only when agreed to by both the Company and the Insured. Arbitration pursuant to this policy and under the Rules shall be binding upon the parties. Judgment upon the award rendered by the Arbitrator(s) may be entered in any court of competent jurisdiction.

14. Liability limited to this policy; policy entire contract

(a) This policy together with all endorsements, if any, attached to it by the Company is the entire policy and contract between the Insured and the Company. In interpreting any provision of this policy, this policy shall be construed as a whole.

(b) Any claim of loss or damage that arises out of the status of the Title or lien of the Insured Mortgage or by any action asserting such claim shall be restricted to this policy.

(c) Any amendment of or endorsement to this policy must be in writing and authenticated by an authorized person, or expressly incorporated by Schedule A of this policy.

(d) Each endorsement to this policy issued at any time is made a part of this policy and is subject to all of its terms and provisions. Except as the endorsement expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsement, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance.

15. Severability. In the event any provision of this policy, in whole or in part, is held invalid or unenforceable under applicable law, the policy shall be deemed not to include that provision or such part held to be invalid, but all other provisions shall remain in full force and effect.

16. Choice of law; forum

(a) Choice of Law: The Insured acknowledges the Company has underwritten the risks covered by this policy and determined the premium charged therefor in reliance upon the law affecting interests in real property and applicable to the interpretation, rights, remedies, or enforcement of policies of title insurance of the jurisdiction where the Land is located.

Therefore, the court or an arbitrator shall apply the law of the jurisdiction where the Land is located to determine the validity of claims against the Title or the lien of the Insured Mortgage that are adverse to the Insured and to interpret and enforce the terms of this policy. In neither case shall the court or arbitrator apply its conflicts of law principles to determine the applicable law.

(b) Choice of Forum: Any litigation or other proceeding brought by the Insured against the Company must be filed only in a state or federal court within the United States of America or its territories having appropriate jurisdiction.

17. Notices, where sent. Any notice of claim and any other notice or statement in writing required to be given to the Company under this policy must be given to the Company at [fill in].

NOTE: Bracketed [ ] material optional

[6-16-86, 4-3-95; 13.14.18.15 NMAC - Rn, 13 NMAC 14.7.A.8 through 14.7.A.12, 5-15-00; A, 8-1-08]

13.14.18.19 NM FORMS 6 AND 6.1: COMMITMENT FOR TITLE INSURANCE AND PLAIN LANGUAGE COMMITMENT FOR TITLE INSURANCE:

Cover page.

Commitment For Title Insurance
Issued By
Blank Title Insurance Company
[NM Form 6; ALTA Form Rev. 2006]

Blank Title Insurance Company, a ___________________ corporation (“Company”), [~~herein called the Company,~~] for a valuable consideration, [~~hereby~~] commits to issue its policy or policies of title insurance, as identified in Schedule A, in favor of the Proposed Insured named in Schedule A, as owner or mortgagee of the estate or interest [~~covered hereby~~] in the land described or referred to in Schedule A, upon payment of the premiums and charges [~~therefore~~] and compliance with the Requirements; all subject to the provisions of Schedules A and B and to the Conditions[~~ and Stipulations hereof~~]of this Commitment.

This Commitment shall be effective only when the identity of the Proposed Insured and the amount of the policy or policies committed for have been inserted in Schedule A [~~hereof~~] by the Company[~~, either at the time of the issuance of this Commitment or by subsequent endorsement~~].

[~~This Commitment is preliminary to the issuance of such policy or policies of title insurance and~~] All liability and obligation [~~hereunder~~]under this Commitment shall cease and terminate___________ (here state the time period)[~~(see Note 1)~~]* after the [~~effective date hereof~~]Effective Date or when the policy or policies committed for shall issue, whichever first occurs, provided that the failure to issue [~~such~~]the policy or policies is not the fault of the Company.

The Company will provide a sample of the policy form upon request.

IN WITNESS WHEREOF, Blank Title Insurance Company has caused its corporate name and seal to be [~~hereunto~~] affixed by its duly authorized officers on the date shown in Schedule A. [~~(see Note 2)~~]**

[. . .]

[~~By~~]Attest: __________________________, Secretary

Note:

[~~Note 1:~~]* The time to be stated is optional with the company and should conform to local usage.

[~~Note 2:~~]** If the Commitment is to be executed by a validating officer, then prior to the “In Witness Whereof” there should be inserted: “This Commitment shall not be valid or binding until countersigned by a validating officer or authorized signatory.” The manner of execution will conform to the company’s practice and will of necessity require some modification in the language identifying the manner of execution. This is deemed a matter of format.

Schedule A.

[. . .]

(Note [~~1~~]: The Company, in printing, should set forth and identify the form or forms of policies of title insurance to be used. If Commitment is printed showing more than one type of policy, the amount of [~~such~~]the policy or policies should be completed and the box checked as to all forms proposed to be issued. The manner of setting up and identifying the policy or policies to be issued is a matter of format.)

3. The estate or interest in the land described or referred to in this Commitment [~~and covered herein~~] is ________________(Identify estate covered, i.e. Fee, Leasehold, etc.) [~~(see Note 2)~~]

4. Title to the ________ estate or interest in [~~said~~]the land is at the Effective Date~~ [hereof~~] vested in: [~~(see Note 2)]~~

5. The land referred to in this Commitment is described as follows:

[~~Note 2: In areas where it is not the custom for title companies to state requirements for insurance, the Commitment would be printed without paragraph numbered 1 of Schedule B and only paragraph numbered 2 would be shown as a caption for Schedule B.~~

~~Note 3: The Committee recommends that separate commitments be issued when a fee and a lesser estate are to be insured simultaneously in favor of different insureds.~~

~~Note 4: At the option of the company and to conform to local practice, an additional paragraph may be added to Schedule A:~~

~~"The mortgage and assignments, if any, covered by this Commitment are described as follows:"~~]

*Items 3 and 4 may be combined or item 3 eliminated completely in instances where the estate to be covered has already been created and is the same as the estate reported on as of the Effective Date of the Commitment. If, however, the estate to be covered is less than a fee and has not yet been created and the estate reported on at the Effective Date of the Commitment is the fee, then it would be more appropriate to set forth both items 3 and 4 in the language suggested or in appropriate language, these being matters of format rather than substance.

Schedule B. [~~(see Note 3)~~]*

1. [~~The following are the requirements to be complied with:~~]Requirements:

(Note [~~1~~]: Appropriate language should be inserted to set forth the requirements of the Company. In many areas, a sub-caption may be used such as: "Instruments in insurable form which must be executed, delivered, and duly filed for record:")

2. Schedule B of the policy or policies to be issued will contain exceptions to the following matters unless the same are disposed of to the satisfaction of the Company:

1. Defects, liens, encumbrances, adverse claims or other matters, if any, created, first appearing in the public records or attaching subsequent to the Effective Date [~~hereof~~] but prior to the date the proposed Insured acquires for value of record the estate or interest or mortgage thereon covered by this Commitment.

Note [~~2~~]: There should be set forth in paragraph numbered [~~2~~]II of Schedule B all matters that would be shown in Schedule B of an Owner's Policy issued on the effective date of the Commitment, including those general exceptions such as rights of parties in possession, survey matters, etc., which in many instances are printed as part of Schedule B of the Policy. It is proper to note that an exception shown may be omitted from the Policy as outside of the coverage of the Policy to be issued, or for some other reason.

[~~Note 3:~~]* In areas where it is not the custom for title companies to state requirements for insurance, the Commitment would be printed without paragraph numbered [~~1~~]I of Schedule B and only paragraph numbered [~~2~~]II would be shown as a caption for Schedule B.

Conditions [~~and Stipulations~~].

[. . .]

2. If the proposed Insured has or [~~acquires~~]acquired actual knowledge of any defect, lien, encumbrance, adverse claim or other matter affecting the estate or interest or mortgage thereon covered by this Commitment other than those shown in Schedule B hereof, and shall fail to disclose such knowledge to the Company in writing, the Company shall be relieved from liability for any loss or damage resulting from any act of reliance hereon to the extent the Company is prejudiced by failure to so disclose such knowledge. If the proposed Insured shall disclose such knowledge to the Company, or if the Company otherwise acquires actual knowledge of any such defect, lien, encumbrance, adverse claim or other matter, the Company at its option may amend Schedule B of this Commitment accordingly, but such amendment shall not relieve the Company from liability previously incurred pursuant to paragraph 3 of these Conditions and Stipulations.

3. Liability of the Company under this Commitment shall be only to the named proposed Insured and such parties included under the definition of Insured in the form of policy or policies committed for and only for actual loss incurred in reliance hereon in undertaking in good faith (a) to comply with the requirements hereof, or (b) to eliminate exceptions shown in Schedule B, or (c) to acquire or create the estate or interest or mortgage thereon covered by this Commitment. In no event shall such liability exceed the amount stated in Schedule A for the policy or policies committed for and such liability is subject to the insuring provisions[~~, the~~]and Conditions and Stipulations and the Exclusions from Coverage of the form of policy or policies committed for in favor of the proposed Insured which are hereby incorporated by reference and are made a part of this Commitment except as expressly modified herein.

4. This Commitment is a contract to issue one or more title insurance policies and is not an abstract of title or a report of the condition of title. Any action or actions or rights of action that the proposed Insured may have or may bring against the Company arising out of the status of the title to the estate or interest or the status of the mortgage thereon covered by this Commitment must be based on and are subject to the provisions of this Commitment.

5. The policy to be issued contains an arbitration clause. All arbitrable matters when the Amount of Insurance is $2,000,000 or less shall be arbitrated at the option of either the Company or the Insured as the exclusive remedy of the parties. You may review a copy of the arbitration rules at< http://www.alta.org/>.

ALTA Plain Language Commitment Form.
Issued By
Blank Title Insurance Company
[NM Form 6.1; ALTA Form Rev. 2006]

INFORMATION

The Title Insurance Commitment is a legal contract between you and the Company. It is issued to show the basis on which we will issue a

Title Insurance Policy to you. The Policy will insure you against certain risks to the land title, subject to the limitations shown in the Policy.

The Company will give you a sample of the Policy form, if you ask.

The Policy contains an arbitration clause. All arbitrable matters when the Amount of Insurance is $2,000,000 or less shall be arbitrated at the option of either the Company or you as the exclusive remedy of the parties. You may review a copy of the arbitration rules at <http://www.alta.org/>.

The Commitment is based on the land title as of the Commitment Date. Any changes in the land title or the transaction may affect the Commitment and the Policy.

The Commitment is subject to its Requirements, Exceptions and Conditions.

THIS INFORMATION IS NOT PART OF THE TITLE INSURANCE COMMITMENT. YOU SHOULD READ THE COMMITMENT VERY CAREFULLY.

If you have any questions about the Commitment, contact ____________________ ____.

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CONDITIONS

Title Insurance Commitment
Issued By
Blank Title Insurance Company

AGREEMENT TO ISSUE POLICY

We agree to issue policy to you according to the terms of the Commitment. When we show the policy amount and your name as the proposed insured in Schedule A, this Commitment becomes effective as of the Commitment Date shown in Schedule A.

If the Requirements shown in this Commitment have not been met within ________________ insert time period ________________ after the Commitment Date, our obligation under this Commitment will end. Also, our obligation under this Commitment will end when the Policy is issued and then our obligation to you will be under the Policy.

Our obligation under this Commitment is limited by the following:

The Provisions in Schedule A.

The Requirements in Schedule B-I.

The Exceptions in Schedule B-II.

The Conditions on Page ______.

This Commitment is not valid without SCHEDULE A and Sections I and II of SCHEDULE B.

(The countersignature clause is optional.)

SCHEDULE A_

1. Commitment Date:

2. Policy (or Policies) to be issued:

a. Owner's Policy Policy Amount $________

Proposed Insured:

b. Loan Policy Policy Amount $________

Proposed Insured:

c. Proposed Insured: Policy Amount $________

3. _______________ interest in the land described in this Commitment is owned, at the Commitment Date, by ____________________.

4. The land referred to in the Commitment is described as follows:

SCHEDULE B - SECTION I

REQUIREMENTS

The following requirements must be met:

a. Pay the agreed amounts for the interest in the land and/or the mortgage to be insured.

b. Pay us the premiums, fees and charges for the policy.

c. Documents satisfactory to us creating the interest in the land and/or the mortgage to be insured must be signed, delivered and recorded.

(A period may be added to the above or a colon may be added and specific documents typed in.)

d. You must tell us in writing the name of anyone not referred to in this Commitment who will get an interest in the land or who will make a loan on the land. We may then make additional requirements or exceptions.

(Additional requirements may be listed here.)

SCHEDULE B - SECTION II

EXCEPTIONS

Any policy we issue will have the following exceptions unless they are taken care of to our satisfaction.

CONDITIONS

1. DEFINITIONS

(a) "Mortgage" means mortgage, deed of trust or other security instrument.

(b) "Public Records" means title records that give constructive notice of matters affecting your title according to the state statutes where your land is located.

2. LATER DEFECTS

The Exceptions in Schedule B - Section II may be amended to show any defects, liens or encumbrances that appear for the first time in the public records or are created or attach between the Commitment Date and the date on which all of the Requirements (a) and (c) of Schedule B - Section I are met. We shall have no liability to you because of this amendment.

3. EXISTING DEFECTS

If any defects, liens or encumbrances existing at Commitment Date are not shown in Schedule B, we may amend Schedule B to show them. If we do amend Schedule B to show these defects, liens or encumbrances, we shall be liable to you according to Paragraph 4 below unless you knew of this information and did not tell us about it in writing.

4. LIMITATION OF OUR LIABILITY

Our only obligation is to issue to you the Policy referred to in this Commitment, when you have met its Requirements. If we have any liability to you for any loss you incur because of an error in this Commitment, our liability will be limited to your actual loss caused by your relying on this Commitment when you acted in good faith to:

Comply with the Requirements shown in Schedule B - Section I

Or

Eliminate with our written consent any Exceptions shown in Schedule B - Section II.

We shall not be liable for more than the Policy Amount shown in Schedule A of this Commitment and our liability is subject to the terms of the Policy form to be issued to you.

6. CLAIMS MUST BE BASED ON THIS COMMITMENT

Any claim, whether or not based on negligence, which you may have against us concerning the title to the land must be based on this Commitment and is subject to its terms.

[6-16-86; 13.14.18.19 NMAC - Rn, 13 NMAC 14.2.A.8, 5-15-00; A, 8-1-08]

13.14.18.25 NM FORM 12: CONDOMINIUM (LENDER'S POLICY) ENDORSEMENT [~~TO LOAN POLICY~~]:

Condominium (Lender's Policy) Endorsement [~~To Loan Policy~~]
Attached To Policy No. ___________
Issued By
Blank Title Insurance Company
[NM Form 12; ALTA Form 4, Rev.[~~3-27-92~~]2006]

The Company insures [~~the insured~~] against loss or damage sustained by the Insured by reason of:

[. . .]

3. Present violations of any restrictive covenants [~~which~~]that restrict the use of the unit and its common elements and [~~which~~]that are contained in the condominium documents[~~, except notations relating to environmental protection unless a notice of a violation thereof has been recorded or filed in the public records and is not excepted in Schedule B~~]. The restrictive covenants do not contain any provisions [~~which~~]that will cause a forfeiture or reversion of the Title. As used in this paragraph 3, the words "restrictive covenants" do not refer to or include any covenant, condition, or restriction (a) relating to obligations of any type to perform maintenance, repair, or remediation on the land, or (b) pertaining to environmental protection of any kind or nature, including hazardous or toxic matters, conditions, or substances, except to the extent that a notice of a violation or alleged violation affecting the Land has been recorded in the Public Records at Date of Policy and is not excepted in Schedule B.

[. . .]

6. Any obligation to remove any improvements [~~which~~]that exist at Date of Policy because of any present encroachments or because of any future unintentional encroachment of the common elements upon any unit or of any unit upon the common elements or another unit.

7. The failure of the Title by reason of a right of first refusal, to purchase the unit and its common elements [~~which~~]that was exercised or could have been exercised at Date of Policy.

[. . .]

[~~By:~~]Authorized Signatory: _______________________________

[6-16-86...4-1-93; 13.14.18.25 NMAC - Rn, 13 NMAC 14.8.A.9, 5-15-00; A, 8-1-08]

13.14.18.26 NM FORM 13 - PLANNED UNIT DEVELOPMENT ENDORSEMENT (LOAN POLICY):

Planned Unit Development Endorsement (Loan Policy)
Attached to Policy No. _____________
Issued by
Blank Title Insurance Company
[NM Form 13; ALTA Form 5, Rev. [~~3-27-92~~]2006]

The Company [hereby] insures against loss or damage sustained by the Insured by reason of:

(1) Present violations of any restrictive covenants referred to in Schedule B which restrict the use of the Land[, except violations relating to environmental protection unless a notice of a violation thereof has been recorded or filed in the public records and is not excepted in Schedule B.] The restrictive covenants do not contain any provisions which will cause a forfeiture or reversion of the Title. As used in this paragraph 1, the words "restrictive covenants" do not refer to or include any covenant, condition or restriction (a) relating to obligations of any type to perform maintenance, repair or remediation on the Land, or (b) pertaining to environmental protection of any kind or nature, including hazardous or toxic matters, conditions, or substances, except to the extent that a notice of a violation or alleged violation affecting the Land has been recorded in the Public Records at Date of Policy and is not excepted in Schedule B.

[. . .]

(4) The failure of the Title by reason of a right of first refusal to purchase the Land [that]which was exercised or could have been exercised at Date of Policy.

[. . .]

[Witness clause optional]

[. . .]

[By]Authorized Signatory ________________________________

[6-16-86...4-1-93; 13.14.18.26 NMAC - Rn, 13 NMAC 14.8.A.10, 5-15-00; A, 8-1-08]

13.14.18.27 NM FORM 13.1: PLANNED UNIT DEVELOPMENT ENDORSEMENT (OWNER'S POLICY):

Planned Unit Development Endorsement (Owner's Policy)
Attached to Policy No. _____________
Issued by
Blank Title Insurance Company
[NM Form 13.1; ALTA Form 5.1, Rev. 2006]

The Company insures against loss or damage sustained by the Insured by reason of:

1. Present violations of any restrictive covenants referred to in Schedule B that restrict the use of the Land. The restrictive covenants do not contain any provisions which will cause a forfeiture or reversion of the Title. As used in this paragraph 1, the words "restrictive covenants" do not refer to or include any covenant, condition, or restriction (a) relating to obligations of any type to perform maintenance, repair, or remediation on the Land, or (b) pertaining to environmental protection of any kind or nature, including hazardous or toxic matters, conditions, or substances, except to the extent that a notice of a violation or alleged violation affecting the Land has been recorded in the Public Records at Date of Policy and is not excepted in Schedule B.

2. Any charges or assessments in favor of any association of homeowners, which are provided for in any document referred to in Schedule B, due and unpaid at Date of Policy.

3. The enforced removal of any existing structure on the Land (other than a boundary wall or fence) because it encroaches onto adjoining land or onto any easements.

4. The failure of the Title by reason of a right of first refusal to purchase the Land that was exercised or could have been exercised at Date of Policy.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

[Witness clause optional]

Dated _____________________

BLANK TITLE INSURANCE COMPANY

Authorized signatory ________________________________

[6-16-86, 5-1-88; 13.14.18.27 NMAC - Rn, 13 NMAC 14.8.A.11, 5-15-00; 13.14.18.27 NMAC - N, 8-1-08]

[~~13.14.18.27~~]13.14.18.28 NM FORM 14: VARIABLE RATE [~~MORTGAGE~~], NEGATIVE AMORTIZATION ENDORSEMENT:

Variable Rate [~~Mortgage~~], Negative Amortization Endorsement
Attached to Policy No.________
Issued by
Blank Title Insurance Company
[NM [~~From~~]Form 14; ALTA Form 6, Rev. [~~6-1-87~~]2006]

The Company insures [~~the owner of the indebtedness secured by the insured mortgage~~] against loss or damage sustained by the Insured by reason of:

1. The invalidity or unenforceability of the lien of the Insured Mortgage resulting from [~~the~~] its provisions [~~therein~~] that provide for changes in the rate of interest.

[. . .]

This endorsement does not insure against loss or damage based upon:

[~~(a)~~]1. usury, or

[~~(b)~~]2. any consumer credit protection or truth in lending law.

[. . .]

[~~By:~~]Authorized signatory ________________________________

[6-16-86, 5-1-88; 13.14.18.28 NMAC - Rn, 13 NMAC 14.8.A.12, 5-15-00; 13.14.18.28 NMAC - Rn, 13.14.18.27 NMAC & A, 8-1-08]

[~~13.14.18.28~~]13.14.18.29 NM FORM 15: VARIABLE RATE [~~MORTGAGE ENDORSEMENT, (~~], NEGATIVE AMORTIZATION[~~)~~] ENDORSEMENT:

Variable Rate [~~Mortgage Endorsement~~], Negative Amortization Endorsement
Attached to Policy No. ____________
Issued By
Blank Title Insurance Company
[NM Form 15; ALTA Form 6.2, Rev. [~~6-1-87~~]2006]

The Company [~~hereby~~] insures against loss or damage sustained by the Insured by reason of:

(1) The invalidity or unenforceability of the lien of the Insured Mortgage resulting from [~~the~~]its provisions [~~therein which~~] that provide for (a) interest on interest [~~and/or~~], (b) changes in the rate of interest [~~and/or~~], or (c) the addition of unpaid interest to the principal balance of the loan.

(2) Loss [~~of~~]or priority of the lien of the Insured Mortgage as security for the [~~unpaid~~] principal balance of the loan, including any unpaid interest which was added to principal in accordance with the provisions of the insured mortgage, interest on interest [~~and/or~~], or interest as changed in accordance with the provisions of the insured mortgage, which loss of priority is caused by [~~said~~](a) changes in the rate of interest [~~and/or~~], (b) interest on interest, [~~and/~~]or (c) increases in the unpaid principal balance of the loan resulting from the addition of unpaid interest.

"Changes in the rate of interest", as used in this endorsement[~~,~~] shall mean only those changes in the rate of interest calculated pursuant to the formula provided in the Insured Mortgage at Date of Policy.

[. . .]

[Witness clause optional]

[. . .]

[~~By:~~]Authorized signatory ________________________________

[6-16-86, 5-1-88; 13.14.18.29 NMAC - Rn, 13 NMAC 14.8.A.13, 5-15-00; 13.14.18.29 NMAC; A, 8-1-01; A, 7-1-05; 13.14.18.29 NMAC - Rn, 13.14.18.28 NMAC & A, 8-1-08]

[~~13.14.18.29~~]13.14.18.30 NM FORM 16: MANUFACTURED HOUSING UNIT ENDORSEMENT:

Manufactured Housing Unit Endorsement

Attached To Policy No.________________
Issued By
Blank Title Insurance Company
[NM Form 16; ALTA Form 7, Rev. [~~6-1-87~~]2006]

The term "Land" [~~as defined in this policy~~] includes the manufactured housing unit located on the land described in Schedule A at Date of Policy.

[. . .]

[~~By:~~]Authorized signatory ________________________________

[6-16-86; 13.14.18.30 NMAC - Rn, 13 NMAC 14.8.A.14, 5-15-00; 13.14.18.30 NMAC - Rn, 13.14.18.29 NMAC & A, 8-1-08]

13.14.18.31 NM FORM 16.1: MANUFACTURED HOUSING - CONVERSION (LOAN) ENDORSEMENT

Manufactured Housing - Conversion (Loan) Endorsement No.______
Attached To Policy No.________________
Issued By Blank Title Insurance Company
[NM Form 16.1; ALTA Form 7.1, Rev. 2006]

1. The term "Land" as defined in this policy includes the manufactured housing unit located on the land described in Schedule A at Date of Policy.

2. Unless excepted in Schedule B, the Company insures against loss or damage sustained by the Insured if, at Date of Policy,

a. A manufactured housing unit is not located on the land described in Schedule A.

b. The manufactured housing unit located on the land is not real property under the law of the state where the Land described in Schedule A is located.

c. The owner of the land is not the owner of the manufactured housing unit.

d. Any lien is attached to the manufactured housing unit as personal property, including

i. a federal, state, or other governmental tax lien,
ii. UCC security interest,
iii. a motor vehicular lien,
iv. other personal property lien.

e. The lien of the Insured Mortgage is not enforceable against the Land.

f. The lien of the Insured Mortgage is not enforceable in a single foreclosure procedure.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

[Witness clause optional]

Dated:_____________________

BLANK TITLE INSURANCE COMPANY

Authorized signatory ________________________________

[5-1-88; 13.14.18.31 NMAC - Rn, 13 NMAC 14.8.A.15, 5-15-00; 13.14.18.31 NMAC - N, 8-1-08]

13.14.18.32 NM FORM 16.2: MANUFACTURED HOUSING - CONVERSION (OWNER'S) ENDORSEMENT

Manufactured Housing - Conversion (Owner's) Endorsement No.______
Attached To Policy No.________________
Issued By
Blank Title Insurance Company
[NM Form 16.2; ALTA Form 7.2, Rev. 2006]

1. The term "Land" as defined in this policy includes the manufactured housing unit located on the land described in Schedule A at Date of Policy.

2. Unless excepted in Schedule B, the Company insures against loss or damage, sustained by the Insured if, at Date of Policy

a. A manufactured housing unit is not located on the land described in Schedule A.

b. The manufactured housing unit located on the land is not real property under the law of the state where the Land described in Schedule A is located.

c. The Insured is not the owner of the manufactured housing unit.

d. Any lien is attached to the manufactured housing unit as personal property, including

i. a federal, state, or other governmental tax lien,

ii. UCC security interest,

iii. a motor vehicular lien,

iv. other personal property lien.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

[Witness clause optional]

Dated:_____________________

BLANK TITLE INSURANCE COMPANY

Authorized signatory ______________________________

[5-1-88; 13.14.18.32 NMAC - Rn, 13 NMAC 14.8.A.16, 5-15-00; 13.14.18.32 NMAC - N, 8-1-08]

[~~13.14.18.33~~]13.14.18.36 NM FORM 20: LEASEHOLD OWNER'S ENDORSEMENT:

Leasehold Owner's Endorsement
Attached to Policy No.____________
Issued by
Blank Title Insurance Company
[NM Form 20; ALTA Form 13, Rev. 2006]

1. As used in this endorsement, [~~the following~~]these terms shall mean the following:

a. "Evicted" or "Eviction": (a) the lawful deprivation, in whole or in part, of the right of possession insured by this policy, contrary to the terms of the Lease or (b) the lawful prevention of the use of the Land or the Tenant Leasehold Improvements for the purposes permitted by the Lease, in either case[~~,~~] as a result of a matter covered by this policy.

[. . .]

[~~2. The provisions of subsection (b) of Section 7 of the Conditions and Stipulations shall not apply to any Leasehold Estate covered by this policy.~~

~~3.~~]2. Valuation of Estate or Interest Insured.

If[~~,~~] in computing loss or damage[~~,~~] it becomes necessary to value the [~~estates or interests of the insured~~]Title as the result of a covered matter that results in an Eviction of the Tenant, then that value shall consist of the value for the Remaining Lease Term of the Leasehold Estate and any Tenant Leasehold Improvements existing on the date of the Eviction. The Insured Claimant shall have the right to have the Leasehold Estate and the Tenant Leasehold Improvements valued either as a whole or separately. In either event, this determination of value shall take into account rent no longer required to be paid for the Remaining Lease Term.

[~~4.~~]3. Additional items of loss covered by this endorsement.

If the Insured is Evicted, the following items of loss, if applicable, shall be included in computing loss or damage incurred by the Insured, but not to the extent that the same are included in the valuation of the [~~estates or interests insured by this policy~~]Title.

[. . .]

b. Rent or damages for use and occupancy of the Land prior to the Eviction [~~which~~]that the Insured as owner of the Leasehold Estate [~~is~~]may be obligated to pay to any person having paramount title to that of the lessor in the Lease.

[. . .]

d. The fair market value, at the time of the Eviction, of the estate or interest of the Insured in any lease or sublease made by [~~the insured~~]Tenant as lessor of all or part of the Leasehold Estate or the Tenant Leasehold Improvements.

e. Damages that the Insured is obligated to pay to lessees or sublessees on account of the breach of any lease or sublease made by the [~~insured~~]Tenant as lessor of all or part of the Leasehold Estate or the Tenant Leasehold Improvements caused by the Eviction.

[. . .]

g. If Tenant Leasehold Improvements are not substantially completed at the time of Eviction, the actual cost incurred by the Insured, less the salvage value, for the Tenant Leasehold Improvements up to the time of Eviction. Those costs include costs incurred to obtain land use, zoning, building and occupancy permits, architectural and engineering fees, construction management fees, costs of environmental testing and reviews, and landscaping costs [~~and fees, costs and interest on loans for the acquisition and construction~~].

[. . .]

[~~BY:~~]Authorized signatory ________________________________

[6-16-86; 13.14.18.36 NMAC - Rn, 13 NMAC 14.8.A.20, 5-15-00; 13.14.18.36 NMAC - Rn, 13.14.18.33 NMAC, & A, 8-1-08]

[~~13.14.18.34~~]13.14.18.37 NM FORM 21: LEASEHOLD LOAN [~~POLICY~~] ENDORSEMENT:

Leasehold Loan [~~Policy~~] Endorsement
Attached to Policy No.___________
Issued By
Blank Title Insurance Company
[NM Form 21; ALTA Form 13.1, Rev. 2006]

1. As used in this endorsement, [~~the following~~]these terms shall mean the following:

[. . .]

e. "Personal Property": chattels located on the Land and property [~~which~~]that, because of their character and manner of affixation to the Land, can be severed from the Land without causing appreciable damage to themselves or to the Land to which they are affixed.

[. . .]

g. "Tenant": the tenant under the Lease and, after acquisition of all or any part of the [~~estate or interest in the land described in Schedule A~~]Title in accordance with the provisions of Section 2[~~(a)~~] of the Conditions [~~and Stipulations~~] of this policy, the Insured Claimant.

[. . .]

2. Valuation of Estate or Interest Insured.

If[~~,~~] in computing loss or damage[~~,~~] it becomes necessary to value the [~~estates or interests insured by this policy~~]Title as the result of a covered matter that results in an Eviction of the Tenant, then that value shall consist of the value for the Remaining Lease Term of the Leasehold Estate and any Tenant Leasehold Improvements existing on the date of the Eviction. The Insured Claimant shall have the right to have the Leasehold Estate and the Tenant Leasehold Improvements valued either as a whole or separately. In either event, this determination of value shall take into account rent no longer required to be paid for the Remaining Lease Term.

3. Additional items of loss covered by this endorsement:

If the Insured acquires all or any part of the [~~estate or interest in the land described in Schedule A~~]Title in accordance with the provisions of Section 2[~~(a)~~] of the Conditions [~~and Stipulations~~] of this policy and thereafter is Evicted, the following items of loss, if applicable, shall be included in computing loss or damage incurred by the Insured, but not to the extent that the same are included in the valuation of the [~~estates or interests insured by this policy~~]Title.

a. The reasonable cost of removing and relocating any Personal Property that the Insured has the right to remove and relocate, situated on the Land at the time of Eviction[,] the cost of transportation of that Personal Property for the initial one hundred miles incurred in connection with the relocation, and the reasonable cost of repairing the Personal Property damaged by reason of the removal and relocation.

b. Rent or damages for use and occupancy of the Land prior to the Eviction [which]that the Insured as owner of the Leasehold Estate may be obligated to pay to any person having paramount title to that of the lessor in the Lease.

[. . .]

d. The fair market value, at the time of the Eviction, of the estate or interest of the Insured in any lease or sublease made by Tenant as lessor of all or part of the Leasehold Estate or the Tenant Leasehold Improvements.

[. . .]

[BY:]Authorized signatory ________________________________

[6-16-86...4-1-94; 13.14.18.37 NMAC - Rn, 13 NMAC 14.8.A.21, 5-15-00; 13.14.18.37 NMAC - Rn, 13.14.18.34 NMAC & A, 8-1-08]

[13.14.18.37]13.14.18.40 NM FORM 24: ASSIGNMENT [OF MORTGAGE] ENDORSEMENT:

Assignment Endorsement
Attached To Policy No. ______
Issued By
Blank Title Insurance Company
[NM Form 24; ALTA Form 10, Rev. 2006]

1. The name of the Insured is amended to read:_______________.

2. The Company insures against loss or damage sustained by the Insured by reason of:

a. The failure of the following assignment to vest title to the Insured Mortgage in the Insured: ____;

b. Any modification, partial or full reconveyance, release, or discharge of the lien of the Insured Mortgage recorded on or prior to Date of Endorsement in the Public Records other than those shown in the policy or a prior endorsement, except: ____;

This endorsement shall be effective provided that the note or notes secured by the lien of the Insured Mortgage have been properly endorsed and delivered to the Insured at Date of Endorsement.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

[Witness clause optional]

Date of Endorsement: ____________

BLANK TITLE INSURANCE COMPANY

Authorized signatory _________________________________.

[6-16-86; 13.14.18.40 NMAC - Rn, 13 NMAC 14.8.A.24, 5-15-00; 13.14.18.40 NMAC - Rn, 13.14.18.37 NMAC & A, 8-1-08]

13.14.18.41 NM FORM 24.1: ASSIGNMENT AND DATE DOWN ENDORSEMENT:

Assignment and Date Down Endorsement
Attached to Policy No._____
Issued By
Blank Title Insurance Company
[NM Form 24.1; ALTA Form 10.1, Rev. 2006]

The Company insures the owner of the Indebtedness secured by the Insured Mortgage against loss or damage sustained by reason of:

1. The name of the Insured is amended to read:_______________.

2. The Company insures against loss or damage sustained by the Insured by reason of

a. The failure of the following assignment to vest title to the Insured Mortgage in the Insured:_______________;

b. Any liens for taxes or assessments that are due and payable on Date or Endorsement, except:_________;

c. Lack of priority of the lien of the Insured Mortgage over defects, liens, or encumbrances other than those shown in the policy or a prior endorsement, except:________;

d. Notices of federal tax liens or notices of pending bankruptcy proceedings affecting the Title and recorded subsequent to Date of Policy in the Public Records and on or prior to Date of Endorsement, except:_____________________________;

e. Any modification, partial or full reconveyance, release or discharge of the lien of the Insured Mortgage recorded on or prior to Date of Endorsement in the Public Records other than those shown in the policy or a prior endorsement, except:___________________________.

This endorsement shall be effective provided that the note or notes secured by the lien of the Insured Mortgage have been properly endorsed and delivered to the Insured at Date of Endorsement.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

[Witness clause optional]

Date of Endorsement__________________________________

BLANK TITLE INSURANCE COMPANY

Authorized signatory ________________________________

[2-6-87; 13.14.18.41 NMAC - Rn, 13 NMAC 14.8.A.25, 5-15-00; 13.14.18.41 NMAC - N, 8-1-08]

[~~13.14.18.41~~]13.14.18.45 NM FORM 28: NON-IMPUTATION - FULL EQUITY TRANSFER ENDORSEMENT:

Non-Imputation - Full Equity Transfer Endorsement
Attached to Policy No. ______
Issued By
Blank Title Insurance Company
[NM Form 28; ALTA Form 15, Rev. 2006]

The Company agrees that it will not assert the provisions of Exclusions from Coverage 3(a), (b), or (e) to deny liability for loss or damage otherwise insured against under the terms of the policy solely by reason of the action or inaction or Knowledge, as of Date of Policy, of

[identify exiting or contributing partner(s) of the insured partnership entity, member(s) or manager(s) of the insured limited liability company entity, or officer(s) and/or director(s) of the insured corporate entity]

whether or not imputed to the Insured by operation of law, provided

[identify the "incoming" partners, members, or shareholders]

acquired the Insured as a purchaser for value without Knowledge of the asserted defect, lien, encumbrance, adverse claim, or other matter insured against by the policy.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements to it.

[Witness clause optional]

Dated: _____________

BLANK TITLE INSURANCE COMPANY

[~~By~~]Authorized signatory ____[~~, President~~

~~Countersigned By: ____________________________, Validating Signatory~~

~~Attest ______________________________________, Secretary~~]

[3-1-91, 4-1-93; 13.14.18.45 NMAC - Rn, 13 NMAC 14.8.A.29, 5-15-00; 13.14.18.45 NMAC - Rn, 13.14.18.41 NMAC &A, 8-1-08]

13.14.18.46 NM FORM 28.1: NON-IMPUTATION - ADDITIONAL INTEREST ENDORSEMENT:

Non-Imputation - Additional Interest Endorsement
Attached to Policy No. _____
Issued by Blank Title Insurance Company
[NM Form 28.1; ALTA Form 15.1, Rev. 2006]

For purposes of the coverage provided by this endorsement,

[identify the "incoming" partner, member or shareholder]

("Additional Insured") is added as an Insured under the policy. By execution below, the Insured named in Schedule A acknowledges that any payment made under this endorsement shall reduce the Amount of Insurance as provided in Section 10 of the Conditions.

The Company agrees that it will not assert the provisions of Exclusions from Coverage 3(a), (b), or (e) to deny liability for loss or damage otherwise insured against under the terms of the policy solely by reason of the action or inaction or Knowledge, as of Date of Policy, of

[identify, as applicable, the existing and/or exiting partner(s) of the insured partnership entity, member(s) or manager(s) of the insured limited liability company entity, or officer(s) and/or director(s) of the insured corporate entity]

whether or not imputed to the Additional Insured by operation of law, to the extent of the percentage interest in the Insured acquired by Additional Insured as a purchaser for value without Knowledge of the asserted defect, lien, encumbrance, adverse claim, or other matter insured against by the policy.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements to it.

AGREED AND CONSENTED TO:

____
INSURED

[Witness clause optional]

Dated _____________________

BLANK TITLE INSURANCE COMPANY

Authorized signatory ______________________________

[4-1-93; 13.14.18.46 NMAC - Rn, 13 NMAC 14.8.A.30, 5-15-00; 13.14.18.46 NMAC - N, 8-1-08]

13.14.18.47 NM FORM 28.2: NON-IMPUTATION - PARTIAL EQUITY TRANSFER ENDORSEMENT

[Incoming partner, member, or shareholder, as the named insured in its own policy, where the vestee of the insured estate or interest identified in Schedule A is a partnership, limited liability company, or corporation]

Non-Imputation - Partial Equity Transfer Endorsement
Attached to Policy No. _____
Issued by Blank Title Insurance Company
[NM Form 28.2; ALTA Form 15.2, Rev. 2006]

The Company agrees that it will not assert the provisions of Exclusions from Coverage 3(a), (b), or (e) to deny liability for loss or damage otherwise insured against under the terms of the policy solely by reason of the action or inaction or Knowledge, as of Date of Policy, of

[identify, as applicable, the existing and/or exiting partner(s) of the vestee partnership entity, member(s) or manager(s) of the vestee limited liability company entity, or officer(s) and/or director(s) of the vestee corporate entity]

whether or not imputed to the entity identified in paragraph 3 of Schedule A or to the Insured by operation of law, but only to the extent that the Insured acquired the Insured's interest in entity as a purchaser for value without Knowledge of the asserted defect, lien, encumbrance, adverse claim, or other matter insured against by the policy.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements to it.

[Witness clause optional]

Dated ____________________

BLANK TITLE INSURANCE COMPANY

Authorized signatory ______________________________

[6-16-86...4-1-93; 13.14.18.47 NMAC - Rn, 13 NMAC 14.6.D.8 through 14.6.D.12, 5-15-00; 13.14.18.47 NMAC - N, 8-1-08]

[~~13.14.18.42~~]13.14.18.48 NM FORM 29: ENVIRONMENTAL PROTECTION LIEN ENDORSEMENT:

Environmental Protection Lien Endorsement
Attached To Policy No. _______
Issued By
Blank Title Insurance Company
[NM Form 29; ALTA Form 8.1, Rev. 2006]

[. . .]

The Company insures [~~the insured~~] against loss or damage sustained by the Insured by reason of lack of priority of the lien of the Insured Mortgage over:

(a) [~~any environmental protection lien which, at Date of Policy, is recorded in the public records or filed in the records of the clerk of the United States district court for the district in which the land is located, except as set forth in Schedule B; or~~] any environmental protection lien that, at Date of Policy, is recorded in those records established under state statutes at Date of Policy for the purpose of imparting constructive notice of matters relating to real property to purchasers for value and without knowledge, or is filed in the records of the clerk of the United States district court for the district in which the Land is located, except as set forth in Schedule B; or

(b) any environmental protection lien provided [~~for~~] by any state statute in effect at Date of Policy, except environmental protection liens provided [~~for~~] by the following state statutes:

[. . .]

[~~By:~~]Authorized signatory ________________________

[4-1-93, 4-3-95, 6-1-98; 13.14.18.48 NMAC - Rn, 13 NMAC 14.2.A.12, 5-15-00; A, 7-1-04; A, 7-1-06; 13.14.18.48 NMAC - Rn, 13.14.18.42 NMAC & A, 8-1-08]

[~~13.14.18.43~~]13.14.18.49 NM FORM 30: CONDOMINIUM (OWNER'S POLICY) ENDORSEMENT [~~TO OWNER'S POLICY~~]:

Condominium (Owner's Policy) Endorsement [~~To Owner's Policy~~]
Attached To Policy No. _______
Issued By
Blank Title Insurance Company
[NM Form [~~29~~]30; ALTA Form 4.1, Rev. 2006]

The Company insures [~~the insured~~] against loss or damage sustained by the Insured by reason of:

[. . .]

3. [~~The failure of the unit and its common elements to be entitled by law to be assessed for real property taxes as a separate parcel.~~] Present violations of any restrictive covenants that restrict the use of the unit and its common elements and that are contained in the condominium documents. The restrictive covenants do not contain any provisions that will cause a forfeiture or reversion of the Title. As used in this paragraph 3, the words "restrictive covenants" do not refer to or include any covenant, condition, or restriction (a) relating to obligations of any type to perform maintenance, repair, or remediation on the land, or (b) pertaining to environmental protection of any kind or nature,

including hazardous or toxic matters, conditions, or substances, except to the extent that a notice of a violation or alleged violation affecting the Land has been recorded in the Public Records at Date of Policy and is not excepted in Schedule B.

4. Any charges or assessments provided for in the condominium statutes and condominium documents due and unpaid at Date of Policy.

5. The failure of the unit and its common elements to be entitled by law to be assessed for real property taxes as a separate parcel.

6. Any obligation to remove any improvements that exist at Date of Policy because of any present encroachments or because of any future unintentional encroachment of the common elements upon any unit or of any unit upon the common elements or another unit.

7. The failure of the Title by reason of a right of first refusal to purchase the unit and its common elements which was exercised or could have been exercised at Date of Policy.

[. . .]

[By:]Authorized signatory ________________________________

[6-16-86...4-1-93; 13.14.18.49 NMAC - Rn, 13 NMAC 14.7.D.8 through 14.7.D.11, 5-15-00; Repealed, 7-1-05; 13.14.18.49 NMAC - Rn, 13.14.18.43 NMAC & A, 8-1-08]

[13.14.18.48]13.14.18.54 NM FORM 35: NOTICE TO [PROPOSED]PURCHASER INSURED:

NOTICE TO [PROPOSED]PURCHASER INSURED
[NM Form 35]

[. . . .]

Standard title insurance policies do not cover certain risks. These risks include the standard exceptions shown on your commitment/binder schedule "B", which will also be part of your policy. Standard Exceptions 1, 2, 3, 4, 5, 6 [and] 7 and 8 (like all the exceptions) limit the coverage under your title policy. However, some of this coverage can be reinstated as described below.

[. . .]

Standard Exception 3 (Survey Protection) excludes coverage for [any problem that an accurate survey would show. Without this coverage, your policy won't insure the accuracy of your survey. If your survey turns out to have inaccurately represented items such as boundaries, easements, location of improvements, etc., the standard policy won't cover any harm you suffer as a result of such inaccuracies.] encroachments, overlaps, conflicts in boundary lines, shortages in area, or other matters which would be disclosed by an accurate survey and inspection of the premises. Standard Exception 3 may be deleted and the coverage reinstated if you meet certain requirements. The charge for this coverage is 15% of the full basic rate, and you must provide a survey meeting the insurer's requirements for insurability.

[. . .]

[6-16-86...4-3-95; 13.14.18.54 NMAC - Rn, 13 NMAC 14.7.E.8 through 14.7.E.11, 5-15-00; 13.14.18.54 NMAC - Rn, 13.14.18.48 NMAC & A, 8-1-08]

[13.14.18.61]13.14.18.67 NM FORM 48: TRUTH IN LENDING ENDORSEMENT:

Truth In Lending Endorsement
Attached to Policy No.________________________
Issued By
Blank Title Insurance Company
[NM Form 48; ALTA Form 2, Rev. 2006]

The Company insures [the owner of the indebtedness secured by the insured mortgage] against loss or damage sustained by the Insured by reason of any final judgment of a court of competent jurisdiction that either the lien of the Insured Mortgage has been terminated or the Title of [the]an Insured, who has acquired all or any part of the [estate or interest in the land described in Schedule A]Land by foreclosure, trustee's sale, conveyance in lieu of foreclosure, or other legal manner, which discharges the lien of the Insured Mortgage, has been defeated by a valid exercise of the right of rescission conferred by the Federal Truth-in-Lending Act and that the right or rights of rescission existed because neither the credit transaction evidenced by the Insured Mortgage nor the right of rescission [thereof] was exempted or excepted by the provisions of Regulation Z (12 CFR 226).

[. . .]

[BY]Authorized signatory: ________________________

[13.14.18.67 NMAC - N, 5-15-00; A, 7-1-06; 13.14.18.67 NMAC - Rn, 13.14.18.61 NMAC & A, 8-1-08]

[~~13.14.18.63~~]13.14.18.69 NM FORM 50: RESTRICTIONS, ENCROACHMENTS, [~~, AND~~] MINERALS - LOAN POLICY ENDORSEMENT:

Restrictions, Encroachments, [~~and~~] Minerals - Loan Policy Endorsement
Attached to Policy No._________________
Issued by
Blank Title Insurance Company
[NM FORM 50; ALTA Form 9; Rev. 2006]

The Company [~~hereby~~] insures the owner of the Indebtedness secured by the Insured Mortgage against loss or damage sustained by reason of:

1. The existence, at Date of Policy, of any of the following:

a. Covenants, conditions, or restrictions under which the lien of the [~~mortgage referred to in Schedule A~~]Insured Mortgage can be divested, subordinated, or extinguished, or its validity, priority, or enforceability impaired.

b. Unless expressly excepted in Schedule B[~~:~~]

(i) Present violations on the Land of any enforceable covenants, conditions, or restrictions, [~~nor of~~]and any existing improvements on the land [~~which~~]described in Schedule A that violate any building setback lines shown on a plat of subdivision recorded or filed in the Public Records.

(ii) Any instrument referred to in Schedule B as containing covenants, conditions, or restrictions on the Land [~~which~~]that, in addition, [~~(i)~~](A) establishes an easement on the Land; [~~(ii)~~](B) provides a lien for liquidated damages; [~~(iii)~~](C) provides for a private charge or assessment; [~~(iv)~~](D) provides for an option to purchase, a right of first refusal, or the prior approval of a future purchaser or occupant.

(iii) Any encroachment of existing improvements located on the Land onto adjoining land, or any encroachment onto the Land of existing improvements located on adjoining land.

(iv) Any encroachment of existing improvements located on the Land onto that portion of the Land subject to any easement excepted in Schedule B.

(v) Any notices of violation of covenants, conditions [~~and~~], or restrictions relating to environmental protection recorded or filed in the Public Records.

2. Any future violation [~~of~~]on the Land of any existing covenants, conditions, or restrictions occurring prior to the acquisition of title to the estate or interest in the Land by the Insured, provided the violation results in[~~:~~]

a. the invalidity, loss of priority, or unenforceability of the lien of the Insured Mortgage; or

b. the loss of Title [~~to the estate or interest in the land~~] if the Insured shall acquire Title in satisfaction of the Indebtedness secured by the Insured Mortgage.

3. Damage to existing improvements, including lawns, shrubbery, or trees:

a. [~~which~~]that are located on or encroach upon that portion of the Land subject to any easement excepted in Schedule B, which damage results from the exercise of the right to maintain the easement for the purpose for which [~~if~~]it was granted or reserved;

(b) resulting from the future exercise of any right to use the surface of the Land for the extraction or development of minerals excepted from the description of the Land or excepted in Schedule B.

4. Any final court order or judgment requiring the removal from any land adjoining the Land of any encroachment excepted in Schedule B.

5. Any final court order or judgment denying the right to maintain any existing improvements on the Land because of any violation of covenants, conditions, or restrictions, or building setback lines shown on a plat of subdivision recorded or filed in the Public Records.

Wherever in this endorsement the words "covenants, conditions, or restrictions" appear, they shall not be deemed to refer to or include the terms, covenants, conditions, or limitations contained in an instrument creating a lease.

As used in paragraphs [~~1(b)(1)~~]1.b(i) and 5, the words " covenants, conditions, or restrictions" [~~shall not be deemed to refer to or~~]do not include any covenants, conditions, or restrictions [~~relating to environmental protection~~] (a) relating to obligations of any type to perform maintenance, repair, or remediation on the Land, or (b) pertaining to environmental protection of any kind or nature, including hazardous or toxic matters, conditions, or substances, except to the extent that a notice of a violation or alleged violation affecting the Land has been recorded or filed in the Public Records at Date of Policy and is not excepted in Schedule B.

[. . .]

[~~BY:~~]Authorized signatory ______________________________

[13.14.18.69 NMAC - N, 3-1-02; 13.14.18.69 NMAC - Rn, 13.14.18.63 NMAC & A, 8-1-08]

13.14.18.70 NM FORM 50.1: RESTRICTIONS, ENCROACHMENTS, MINERALS - LOAN POLICY ENDORSEMENT

Restrictions, Encroachments, Minerals - Loan Policy Endorsement
Attached to Policy No. _____
Issued by
Blank Title Insurance Company
[NM Form 50.1; ALTA Form 9.3, Rev. 2006]

The Company insures the owner of the Indebtedness secured by the Insured Mortgage against loss or damage sustained by reason of:

1. The existence at Date of Policy of any of the following:

a. Covenants, conditions, or restrictions under which the lien of the insured mortgage can be divested, subordinated or extinguished, or its validity, priority or enforceability impaired.

b. Unless expressly excepted in Schedule B:

(i) Present violations on the land of any enforceable covenants, conditions, or restrictions, and any existing improvements on the land which violate any building setback lines shown on a plat of subdivision recorded or filed in the public records.

(ii) Any instrument referred to in Schedule B as containing covenants, conditions, or restrictions on the land that, in addition, (A) establishes an easement on the land; (B) provides a lien for liquidated damages; (C) provides for a private charge or assessment; (D) provides for an option to purchase, a right of first refusal, or the prior approval of a future purchaser or occupant.

(iii) Any encroachment of existing improvements located on the land onto adjoining land, or any encroachment onto the land of existing improvements located on adjoining land.

(iv) Any encroachment of existing improvements located on the land onto that portion of the land subject to any easement excepted in Schedule B.

(v) Any notices of violation of covenants, conditions, or restrictions relating to environmental protection recorded or filed in the public records.

2. Any future violation on the land of any existing covenants, conditions, or restrictions occurring prior to the acquisition of title by the Insured, provided the violation results in

(a) invalidity, loss of priority, or unenforceability of the lien of the insured mortgage; or

(b) loss of Title if the Insured shall acquire title in satisfaction of the indebtedness.

3. Damage to existing improvements, including lawns, shrubbery, or trees, located or encroaching on that portion of the land subject to any easement excepted in Schedule B, which damage results from the exercise of the right to maintain the easement for the purpose for which it was granted or reserved.

4. Damage to improvements, including lawns, shrubbery, or trees, located on the land on or after Date of Policy resulting from the future exercise of any right to use the surface of the land for the extraction or development of minerals excepted from the description of the land or excepted in Schedule B.

5. Any final court order or judgment requiring the removal from any land adjoining the land of any encroachment excepted in Schedule B.

6. Any final court order or judgment denying the right to maintain any existing improvements on the land because of any violation of covenants, conditions, or restrictions, or building setback lines shown on a plat of subdivision recorded or filed in the public records.

Wherever in this endorsement the words "covenants, conditions, or restrictions" appear, they do not include the terms, covenants, conditions, or limitations contained in an instrument creating a lease.

As used in paragraphs 1.b(1) and 6, the words "covenants, conditions or restrictions" do not include any covenants, conditions, or restrictions (a) relating to obligations of any type to perform maintenance, repair or remediation on the land, or (b) pertaining to environmental protection of any kind or nature, including hazardous or toxic matters, conditions, or substances, except to the extent that a notice of a violation or alleged violation affecting the land has been recorded or filed in the public records at Date of Policy and is not excepted in Schedule

B.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

[Witness clause optional]

Dated ____________________

BLANK TITLE INSURANCE COMPANY

Authorized signatory ______________________________

[13.14.18.70 NMAC - N, 3-1-02; 13.14.18.70 NMAC - N, 8-1-08]

[~~13.14.18.67~~]13.14.18.74 NM FORM 54: CONTIGUITY [~~OF~~] SINGLE PARCEL ENDORSEMENT:

[For use when the insured desires contiguity coverage between the Land and some other parcel of land]

Contiguity [~~of~~] Single Parcel Endorsement
Attached to Policy No. ___________
Issued By
Blank Title Insurance Company
[NM Form 54; ALTA Form 19.1, Rev. 2006]

The Company [~~hereby~~] insures against loss or damage sustained by the Insured by reason of:

[~~(1) the failure of the land to be contiguous along its ____________ boundary line to [describe the land that is contiguous to the "land" as defined in the policy by its legal description or by reference to a recorded instrument e.g. "…that certain parcel of real property legally described in the deed recorded as Instrument No. __________, records of________ County, State of New Mexico]; or~~

~~(2) the presence of any gaps, strips or gores separating the contiguous boundary line described above.~~]

1. the failure of the Land to be contiguous to **[describe the land that is contiguous to the Land by its legal description or by reference to a recorded instrument - e.g. ". . . that certain parcel of real property legally described in the deed recorded as Instrument No. ______________, records of ____________ County, State of ______]** along the ______boundary line[s]; or

2. the presence of any gaps, strips, or gores separating the contiguous boundary lines described above.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements to it.

[Witness clause optional]

Dated: ________________________________

BLANK TITLE INSURANCE COMPANY

[~~BY~~]Authorized signatory____________________________________

[13.14.18.74 NMAC - N, 7-1-04; 13.14.18.74 NMAC - Rn, 13.14.18.67 NMAC & A, 8-1-08]

[~~13.14.18.69~~]13.14.18.76 NM FORM 56: RESTRICTIONS, ENCROACHMENTS, [~~AND MINERALS ENDORSEMENT FOR UNIMPROVED LAND~~]MINERALS - OWNER'S POLICY (UNIMPROVED LAND) ENDORSEMENT:

Restrictions, Encroachments, [~~and~~] Minerals - Owner's Policy (Unimproved Land) Endorsement [~~for Unimproved Land~~]
Attached to Policy No. _____
Issued by
Blank Title Insurance Company
[NM FORM 56; ALTA Form 9.1, Rev. 2006]

The Company insures [~~the insured~~]against loss or damage sustained by the Insured by reason of:

1. **[. . .]**

(b) Any instrument referred to in Schedule B as containing covenants, conditions, or restrictions on the Land [~~which~~]that, in addition, (i) establishes an easement on the Land; (ii) provides for an option to purchase, a right of first refusal, or the prior approval of a future purchaser or occupant; or (iii) provides a right of reentry, possibility of reverter, or right of forfeiture because of violations on the Land of any enforceable covenants, conditions, or restrictions.

[. . .]

(d) Any notices of violation of covenants, conditions, [~~and~~]or restrictions relating to environmental protection recorded or filed in the Public Records.

[. . .]

As used in paragraph 1.a., the words "covenants, conditions, or restrictions" [~~shall not be deemed to refer to or include any covenants, conditions, or restrictions relating to environmental protection~~] do not include any covenants, conditions, or restrictions (a) relating to obligations of any type to perform maintenance, repair, or remediation on the Land, or (b) pertaining to environmental protection of any kind or nature, including hazardous or toxic matters, conditions, or substances, except to the extent that a notice of a violation or alleged violation affecting the Land has been recorded or filed in the Public Records at Date of Policy and is not excepted in Schedule B.

[. . .]

[~~BY:~~]Authorized signatory _________________

[13.14.18.76 NMAC - N, 7-1-04; 13.14.18.76 NMAC - Rn, 13.14.18.69 NMAC & A, 8-1-08]

13.14.18.77 NM FORM 56.1: RESTRICTIONS, ENCROACHMENTS, MINERALS ENDORSEMENT (OWNER'S POLICY - UNIMPROVED LAND)

Restrictions, Encroachments, Minerals Endorsement (Owner's Policy - Unimproved Land)
Attached to Policy No. _____
Issued by
Blank Title Insurance Company
[NM Form 56.1; ALTA Form 9.4, Rev. 2006]

The Company insures against loss or damage sustained by the Insured by reason of:

1. The existence, at Date of Policy, of any of the following unless expressly excepted in Schedule B:

a. Present violations on the land of any enforceable covenants, conditions, or restrictions,

b. Any instrument referred to in Schedule B as containing covenants, conditions, or restrictions on the land that, in addition, (i) establishes an easement on the land; (ii) provides for an option to purchase, a right of first refusal, or the prior approval of a future purchaser or occupant; or (iii) provides a right of reentry, possibility of reverter, or right of forfeiture because of violations on the land of any enforceable covenants, conditions, or restrictions.

c. Any encroachment onto the land of existing improvements located on adjoining land.

d. Any notices of violation of covenants, conditions, or restrictions relating to environmental protection recorded or filed in the public records.

2. Damage to improvements (excluding lawn, shrubbery, or trees) constructed on the land after Date of Policy resulting from the future exercise of any right existing at Date of Policy to use the surface of the land for the extraction or development of minerals excepted from the description of the land or excepted in Schedule B.

Wherever in this endorsement the words "covenants, conditions, or restrictions" appear, they do not include the terms, covenants, conditions, or limitations contained in an instrument creating a lease.

As used in paragraphs 1.a., the words "covenants, conditions, or restrictions" do not include any covenants, conditions, or restrictions (a) relating to obligations of any type to perform maintenance, repair, or remediation on the land, or (b) pertaining to environmental protection of any kind or nature, including hazardous or toxic matters, conditions, or substances, except to the extent that a notice of a violation or alleged violation affecting the land has been recorded or filed in the public records at Date of Policy and is not excepted in Schedule B.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls.

Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

[Witness clause optional]

Dated ____________________

BLANK TITLE INSURANCE COMPANY

Authorized signatory ______________________________

[13.14.18.77 NMAC - N, 7-1-05; 13.14.18.77 NMAC - N, 8-1-08]

[13.14.18.70]13.14.18.78 NM FORM 57: RESTRICTIONS, ENCROACHMENTS, [AND MINERALS ENDORSEMENT FOR IMPROVED LAND:] MINERALS - OWNER'S POLICY (IMPROVED LAND) ENDORSEMENT:

Restrictions, Encroachments, [and Minerals Endorsement for Improved Land]Minerals - Owner's Policy (Improved Land) Endorsement
Attached to Policy No. _____
Issued by
Blank Title Insurance Company
[NM FORM 57; ALTA Form 9.2, Rev. 2006]

The Company insures [the insured] against loss or damage sustained by the Insured by reason of:

1. **[. . .]**

(b) Any instrument referred to in Schedule B as containing covenants, conditions, or restrictions on the land [which]that, in addition, (i) establishes an easement on the land; (ii) provides for an option to purchase, a right of first refusal, or the prior approval of a future purchaser or occupant; or (iii) provides a right of reentry, possibility of reverter, or right of forfeiture because of violations on the land of any enforceable covenants, conditions, or restrictions.

[. . .]

(e) Any notices of violation of covenants, conditions, [and]or restrictions relating to environmental protection recorded or filed in the public records.

2. Damage to existing buildings[:]

(a) [Which]That are located on or encroach upon that portion of the land subject to any easement excepted in Schedule B, which damage results from the exercise of the right to maintain the easement for the purpose for which [is]it was granted or reserved;

[. . .]

4. Any final court order or judgment denying the right to maintain any existing building on the land because of any violation of covenants, conditions, or restrictions, or [buildings]building setback lines shown on a plat of subdivision recorded or filed in the public records.

[. . .]

As used in paragraphs 1.a. and 4, the words "covenants, conditions, or restrictions" [shall not be deemed to refer to or] do not include any covenants, conditions, or restrictions [relating to environmental protection] (a) relating to obligations of any type to perform maintenance, repair, or remediation on the land, or (b) pertaining to environmental protection of any kind or nature, including hazardous or toxic matters, conditions or substances, except to the extent that a notice of a violation or alleged violation affecting the land has been recorded or filed in the public records at Date of Policy and is not excepted in Schedule B.

[. . .]

[BY:]Authorized signatory _________________

[13.14.18.78 NMAC - N, 7-1-05; 13.14.18.78 NMAC - Rn, 13.14.18.70 NMAC & A, 8-1-08]

13.14.18.79 NM FORM 57.1: RESTRICTIONS, ENCROACHMENTS, MINERALS (OWNER'S POLICY - IMPROVED LAND) ENDORSEMENT

Restrictions, Encroachments, Minerals (Owner's Policy - Improved Land) Endorsement
Attached to Policy No. _____

Issued by
Blank Title Insurance Company
[NM Form 57.1; ALTA Form 9.5, Rev. 2006]

The Company insures against loss or damage sustained by the Insured by reason of:

1. The existence, at Date of Policy, of any of the following unless expressly excepted in Schedule B:

a. Present violations on the land of any enforceable covenants, conditions, or restrictions, or any existing improvements on the land which violate any building setback lines shown on a plat of subdivision recorded or filed in the public records.

b. Any instrument referred to in Schedule B as containing covenants, conditions, or restrictions on the land that, in addition, (i) establishes an easement on the land; (ii) provides for an option to purchase, a right of first refusal, or the prior approval of a future purchaser or occupant; or (iii) provides a right of reentry, possibility of reverter, or right of forfeiture because of violations on the land of any enforceable covenants, conditions, or restrictions.

c. Any encroachment of existing improvements located on the land onto adjoining land, or any encroachment onto the land of existing improvements located on adjoining land.

d. Any encroachment of existing improvements located on the land onto that portion of the land subject to any easement excepted in Schedule B.

e. Any notices of violation of covenants, conditions, or restrictions relating to environmental protection recorded or filed in the public records.

2. Damage to existing buildings that are located on or encroach upon that portion of the land subject to any easement excepted in Schedule B, which damage results from the exercise of the right to maintain the easement for the purpose for which is was granted or reserved.

3. Damage to improvements (excluding lawns, shrubbery, or trees), located on the land on or after Date of Policy resulting from the future exercise of any right existing at Date of Policy to use the surface of the land for the extraction or development of minerals excepted from the description of the land or excepted in Schedule B.

4. Any final court order or judgment requiring the removal from any land adjoining the Land of any encroachment, other than fences, landscaping, or driveways, excepted in Schedule B.

5. Any final court order or judgment denying the right to maintain any existing building on the land because of any violation of covenants, conditions, or restrictions, or buildings setback lines shown on a plat of subdivision recorded or filed in the public records.

Wherever in this endorsement the words "covenants, conditions, or restrictions" appear, they do not include the terms, covenants, conditions, or limitations contained in an instrument creating a lease.

As used in paragraphs 1.a. and 5, the words "covenants, conditions, or restrictions" do not include any covenants, conditions, or restrictions (a) relating to obligations of any type to perform maintenance, repair, or remediation on the land, or (b) pertaining to environmental protection of any kind or nature, including hazardous or toxic matters, conditions, or substances, except to the extent that a notice of a violation or alleged violation affecting the land has been recorded or filed in the public records at Date of Policy and is not excepted in Schedule B.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

[Witness clause optional]

Dated_____________________

BLANK TITLE INSURANCE COMPANY

Authorized signatory _______________________________

[13.14.18.79 NMAC - N, 7-1-06; 13.14.18.79 NMAC - N, 8-1-08]

[~~13.14.18.71~~]13.14.18.80 NM FORM 58: FIRST LOSS - MULTIPLE PARCEL TRANSACTIONS ENDORSEMENT:

First Loss - Multiple Parcel Transactions Endorsement
Attached to Policy No. __________

Issued by Blank Title Insurance Company
[NM Form 58; ALTA Form 20, Rev. 2006]

This endorsement is effective only if the Collateral includes at least two parcels of real property.

1. For the purposes of this endorsement

a. "Collateral" means all property, including the Land, given as security for the Indebtedness.

b. "Material Impairment Amount" means the amount by which any matter covered by this policy for which a claim is made diminishes the value of the Collateral below the Indebtedness.

2. In the event of a claim resulting from a matter insured against by this policy, the Company agrees to pay that portion of the Material Impairment Amount that does not exceed the limits of liability imposed by Sections 2 and 8 of the Conditions without requiring

a. maturity of the Indebtedness by acceleration or otherwise,

b. pursuit by the Insured of its remedies against the Collateral,

c. pursuit by the Insured of its remedies under any guaranty, bond or other insurance policy.

3. Nothing in this endorsement shall impair the Company's right of subrogation. However, the Company agrees that its right of subrogation shall be subordinate to the rights and remedies of the Insured. The Company's right of subrogation shall include the right to recover the amount paid to the Insured pursuant to paragraph 2 from any debtor or guarantor of the Indebtedness, after payment or other satisfaction of the remainder of the Indebtedness and other obligations secured by the lien of the Insured Mortgage. The Company shall have the right to recoup from the Insured Claimant any amount received by it in excess of the Indebtedness up to the amount of the payment under paragraph 2.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

[Witness clause optional]

BLANK TITLE INSURANCE COMPANY

BY: ____________________

[13.14.18.80 NMAC - N, 7-1-06; 13.14.18.80 NMAC - Rn, 13.14.18.71 NMAC & A, 8-1-08]

[~~13.14.18.73~~]13.14.18.82 NM FORM 60: [~~LOAN POLICY~~] AGGREGATION ENDORSEMENT:

[~~Loan Policy~~] Aggregation Endorsement
Attached to Policy No. __________
Issued By Blank Title Insurance Company
[NM Form 60; ALTA Form 12, Rev. 2006]

[. . . .]

Notwithstanding the provisions of Section [~~7~~]8(a)(i) of the Conditions [~~and Stipulations~~] of this policy, the Amount of Insurance available to cover the Company's liability for loss or damage under this policy at the time of payment of loss hereunder shall be the aggregate of the Amount of Insurance under this policy and the other policies identified above. At no time shall the Amount of Insurance under this policy and the other policies identified above exceed in the aggregate $______________. Subject to the provisions of Section [~~9~~] 10(a) of the Conditions [~~and Stipulations~~]of the policies, all payments made by the Company under this policy or any of the other policies identified above, except the payments made for costs, attorney's fees, and expenses, shall reduce the aggregate Amount of Insurance [~~pro tanto~~] by the amount of the payment.

[. . .]

Authorized signatory ____________________

[13.14.18.82 NMAC - Rn, 13.14.18.73 NMAC & A, 8-1-08]

[~~13.14.~~18.76]13.14.18.85 NM FORM 63: SHORT FORM RESIDENTIAL LOAN POLICY:

Short Form Residential Loan Policy - One-to-Four Family
Issued By Blank Title Insurance Company
[NM Form 63; ALTA Form Rev. 2006]

Schedule A.

[~~Amount of Insurance:~~
~~[Premium:]~~
~~[File Number:]~~
~~Mortgage Amount:~~
~~Policy Number:~~
~~Loan Number:~~
~~Mortgage Date:~~
~~Date of Policy: ____________________ or the date of recording of the insured mortgage, whichever is later.~~
~~Name of Insured:~~
~~Name of Borrower(s):~~
~~Property Address:~~
~~County and State:~~]

Name and Address of Title Insurance Company:
[File No.:]
Policy No.:
Loan No.:
Address Reference: ___________________
Street Address: _____________________
County and State:
Amount of Insurance: $
[Premium: $ ___________]
Mortgage Amount: $
Mortgage Date:
Date of Policy: [at a.m./p.m.]
Name of Insured:
Name of Borrower(s):

The estate or interest in the Land identified in this Schedule A and which is encumbered by the Insured Mortgage is fee simple and is, at Date of Policy, vested in the borrower(s) shown in the Insured Mortgage and named above.

The Land referred to in this policy is described as set forth in the Insured Mortgage [~~and is identified as the property address shown above~~].

This policy consists of [one] page(s), [including [~~the~~]its reverse side,] unless an addendum is attached and indicated below:

____ Addendum attached

[~~The endorsements indicated below are incorporated herein:~~

~~___ NM Form 12 (ALTA 4), Condominium Endorsement~~
~~___ NM Form 13, (ALTA 5), Planned Housing Unit Endorsement~~
~~___ NM Form 14 (ALTA 6), Variable Rate Endorsement~~
~~___ NM Form 15 (ALTA 6.2), Variable Rate - Negative Amortization Endorsement~~
~~___ NM Form 16 (ALTA 7), Manufactured Housing Unit Endorsement~~
~~___ NM Form 29 (ALTA 8.1), Environmental Protection Lien Endorsement, referring to the following New Mexico Statute(s):~~
~~NMSA 1978 Section(s) ____~~]

Subject to the conditions stated in the endorsement list below, the following ALTA endorsements are incorporated in this policy:

ALTA ENDORSEMENT 4.1-06 (Condominium), if the Land or estate or interest is referred to in the Insured Mortgage as a condominium.

ALTA ENDORSEMENT 5.1-06 (Planned Unit Development)

ALTA ENDORSEMENT 6-06 (Variable Rate), if the Insured Mortgage contains provisions which provide for an adjustable interest rate.

ALTA ENDORSEMENT 6.2-06 (Variable Rate-Negative Amortization), if the Insured Mortgage contains provisions which provide for both an adjustable interest rate and negative amortization.

ALTA ENDORSEMENT 7-06 (Manufactured Housing), if a manufactured housing unit is located on the Land at Date of Policy.

ALTA ENDORSEMENT 8.1-06 (Environmental Protection Lien) - Paragraph b refers to the following state statute(s):

ALTA ENDORSEMENT 9-06 (Restrictions, Encroachments, Minerals)

The endorsements checked below, if any, are incorporated in this policy:

_ ALTA ENDORSEMENT 4-06 (Condominium)

_ ALTA ENDORSEMENT 5-06 (Planned Unit Development)

_ ALTA ENDORSEMENT 7.1-06 (Manufactured Housing - Conversion; Loan)

[. . . .]

[[bracketed material optional]]

SUBJECT TO THE EXCEPTIONS FROM COVERAGE CONTAINED IN SCHEDULE B BELOW, AND ANY ADDENDUM ATTACHED HERETO, BLANK TITLE INSURANCE COMPANY, A [BLANK]___________ CORPORATION, HEREIN CALLED THE "COMPANY," HEREBY INSURES THE INSURED IN ACCORDANCE WITH AND SUBJECT TO THE TERMS, EXCLUSIONS[,]AND CONDITIONS [AND STIPULATIONS] SET FORTH IN THE AMERICAN LAND TITLE ASSOCIATION LOAN POLICY ([10-17-92]6-17-06), [(NM Form 2),] ALL OF WHICH ARE INCORPORATED HEREIN. ALL REFERENCES TO SCHEDULES A AND B SHALL REFER TO SCHEDULES A AND B OF THIS POLICY.

SCHEDULE B - Exceptions from coverage and affirmative coverage.

Except to the extent of the affirmative insurance set forth below, this policy does not insure against loss or damage (and the Company will not pay costs, [attorneys']attorney's fees, or expenses) which arise by reason of:

1. Those taxes and special assessments that become due [and] or payable subsequent to Date of Policy. (This does not modify or limit the coverage provided in covered risks 11(b).

2. Covenants, conditions, [and]or restrictions, if any, appearing in the Public Records; however, this policy insures against loss or[t] damage arising from:

a. the violation of [any]those covenants, conditions, [and]or restrictions on or prior to Date of Policy; [except that this affirmative insurance does not extend to covenants, conditions and restrictions relating to environmental protections, unless a notice of a violation thereof has been recorded or filed in the public records and is not referenced in an addendum attached to this policy.]

b. a forfeiture or reversion of Title from a future violation of [any]those covenants, conditions, [and]or restrictions [appearing in the public records, including any], including those relating to environmental protection; and

c. [any] provisions in [any]those covenants, conditions, [and]or restrictions, including those relating to environmental protection, under which the lien of the Insured Mortgage can be extinguished, subordinated, or impaired.

As used in paragraph 2(a), the words "covenants, conditions, or restrictions" do not refer to or include any covenant, condition, or restriction (a) relating to obligations of any type to perform maintenance, repair or remediation on the Land, or (b) pertaining to environmental protection of any kind or nature, including hazardous or toxic matters, conditions, or substances, except to the extent that a notice of a violation or alleged violation affecting the Land has been recorded or filed in the Public Records at Date of Policy and is not referenced in an addendum attached to this policy.

3. Any easements or servitudes appearing in the Public Records; however this policy insures against loss or damage arising from[:] (a) the encroachment, at Date of Policy, of the improvements on any easement[;], and (b) any interference with or damage to existing improvements, including lawns, shrubbery, and trees, resulting from the use of the easements for the purposes granted or reserved.

4. Any lease, grant, exception, or reservation of minerals or mineral rights appearing in the Public Records; however, this policy insures against loss or damage arising from[:]

(a) any [effect]affect on or impairment of the use of the Land for residential one-to-four family dwelling purposes by reason of such lease, grant, exception or reservation of minerals or mineral rights[;], and

(b) any damage to existing improvements, including lawns, shrubbery, and trees, resulting from the future exercise of any right to use the surface of the Land for the extraction or development of the minerals or mineral rights so leased, granted, excepted, or reserved.

[c.] Nothing herein shall insure against loss or damage resulting from subsidence.

[5. This policy insures against loss or damage by reason of any violation, variation, encroachment or adverse circumstance affecting the title that would have been disclosed by an accurate survey. The term "encroachment" includes encroachment of existing improvements located on the land onto adjoining land, and encroachments onto the land of existing improvements located on adjoining land.

6. In compliance with subsection D of 13.14.18.10 NMAC, the company hereby waives its right to demand arbitration pursuant to the Title Insurance Arbitration Rules of the American Arbitration Association. Nothing herein prohibits the arbitration of all arbitrable matters when agreed to by both the Company and insured.

7. Water rights, claims or title to water.]

NOTICES, WHERE SENT: Any notice of claim or other notice or statement in writing required to be given the Company under this policy must be given to the Company at the following address: ____.

SCHEDULE B continued - Addendum to short form residential loan policy

[File Number:]
Addendum to Policy Number:___________
[File Number: _________]

IN ADDITION TO THE MATTERS SET FORTH ON SCHEDULE B OF THE POLICY TO WHICH THIS ADDENDUM IS ATTACHED, THIS POLICY DOES NOT INSURE AGAINST LOSS OR DAMAGE (AND THE COMPANY WILL NOT PAY COSTS, ATTORNEYS' FEES OR EXPENSES) THAT ARISE BY REASON OF THE FOLLOWING:

[13.14.18.85 NMAC - Rn, 13.14.18.76 NMAC & A, 8-1-08]

[13.14.18.77]13.14.18.86 NM FORM 64: ZONING [ENDORSEMENT,]- UNIMPROVED LAND ENDORSEMENT:

Zoning [Endorsement,]- Unimproved Land Endorsement
Attached to Policy No. __________
Issued By Blank Title Insurance Company
[NM Form 64; ALTA Form [3.0] 3, Rev. [10-17-98]2006]

1. The Company insures [the insured] against loss or damage sustained by the Insured in the event that, at Date of Policy[:],

[1.]a. According to applicable zoning ordinances and amendments [thereto], the Land is not classified Zone______;

[2.]b. The following use or uses are not allowed under that classification:

2. There shall be no liability under this endorsement based on[:]

(a) Lack of compliance with any conditions, restrictions, or requirements contained in the zoning ordinances and amendments [thereto mentioned above], including but not limited to the failure to secure necessary consents or authorizations as a prerequisite to the use or uses. This paragraph 2.a. does not modify or limit the coverage provided in Covered Risk 5.

(b) The invalidity of the zoning ordinances and amendments [thereto mentioned above] until after a final decree of a court of competent jurisdiction adjudicating the invalidity, the effect of which is to prohibit the use or uses.

(c) The refusal of any person to purchase, lease or lend money on the estate or interest covered by this policy.

[. . .]

[BY:]Authorized signatory_____________________

[13.14.18.86 NMAC - Rn, 13.14.18.77 NMAC & A, 8-1-08]

[13.14.18.78]13.14.18.87 NM FORM 65: ZONING [ENDORSEMENT,]- COMPLETED STRUCTURE ENDORSEMENT:

Zoning [Endorsement,]- Completed Structure Endorsement
Attached to Policy No. __________
Issued By Blank Title Insurance Company
[NM Form 65; ALTA Form 3.1, Rev. [10-17-98]2006]

1. The Company insures [the insured] against loss or damage sustained by the Insured in the event that, at Date of Policy[:],

(a) according to applicable zoning ordinances and amendments [thereto], the Land is not classified Zone________;

(b) the following use or uses are not allowed under that classification:

[~~and~~](c) There shall be no liability under [~~this~~] paragraph 1.b. if the use or uses are not allowed as [~~a~~]the result of any lack of compliance with any conditions, restrictions, or requirements contained in the zoning ordinances and amendments [~~thereto mentioned above~~], including but not limited to the failure to secure necessary consents or authorizations as a [~~prerequisite~~] perquisite to the use or uses. This paragraph 1.c. does not modify or limit the coverage provided in Covered Risk 5.

2. The Company further insures against loss or damage [~~arising from~~]sustained by the Insured by reason of a final decree of a court of competent jurisdiction[~~:~~]

(a) prohibiting the use of the Land, with any existing structure [~~presently located thereon~~], as [~~specified~~] insured in paragraph 1.b.; or

(b) requiring the removal or alteration of the structure on the basis that, at Date of Policy, the zoning ordinances and amendments [~~thereto~~] have been violated with respect to any of the following matters:

[. . .]

3. There shall be no liability under this endorsement based on:

(a) the invalidity of the zoning ordinances and amendments [~~thereto mentioned above~~] until after a final decree of a court of competent jurisdiction adjudicating the invalidity, the effect of which is to prohibit the use or uses;

(b) the refusal of any person to purchase, lease, or lend money on the estate or interest covered by this policy.

[. . .]

[~~BY:~~]Authorized signatory:______________________

[13.14.18.87 NMAC - Rn, 13.14.18.78 NMAC & A, 8-1-08]

[~~13.14.18.79~~]13.14.18.88 NM FORM 66: CONTIGUITY [~~OF~~]- MULTIPLE PARCELS ENDORSEMENT:

Contiguity [~~of~~]- Multiple Parcels Endorsement
Attached to Policy No.
Issued By
Blank Title Insurance Company
[NM Form 66; ALTA Form 19, Rev. 2006]

The Company [~~hereby~~] insures against loss or damage sustained by the Insured by reason of:

(1) the failure [of the _________ boundary line of Parcel A] of the land to be contiguous to [the __________ boundary line of Parcel B] **[For more than two parcels, continue as follows: [~~"~~] "; of [the _________ boundary line of Parcel B] of the Land to be contiguous to [the _________ boundary line of Parcel C] and so on until all contiguous parcels described in the policy have been accounted for.]**; or

(2) the presence of any gaps, strips, or gores separating any of the contiguous boundary lines described above.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Dated: __________________________________

[. . .]

[~~BY~~]Authorized signatory _____________________________________
[13.14.18.88 NMAC - Rn, 13.14.18.79 NMAC & A, 8-1-08]

NEW MEXICO DEPARTMENT OF PUBLIC SAFETY

This is an amendment to 10.10.2 NMAC Sections 10, 11, 12, 14, and 15, effective July 31, 2008.

10.10.2.10 AUTHORIZED PROJECTS/PROGRAM AREAS

A. Authorized programs for [~~2007~~] 2008 funding are listed below. Descriptions for each program can be found in attachment A. Approved program purpose areas:

(1) law enforcement

(2) planning, evaluation and technology, limited to evaluation only

B. Applicants may request copies of the New Mexico drug strategy by writing the Department of Public Safety, [~~Grants Accountability and Compliance Section~~] Grants Management Bureau, Post Office Box 1628, Santa Fe, New Mexico 87504 or by calling ~~[(505) 827-9112~~] (505) 827-3347.

[10.10.2.10 NMAC - Rp 10 NMAC 10.2.10, 3-15-00; A, 05-31-02; A, 05-28-04; A, 07-29-05; A, 07-31-07; A, 07-31-08]

10.10.2.11 APPLICATION REQUIREMENTS: All applicants for funding under the JAG formula grant program must adhere to the following procedures.

A. Each applicant shall forward **an original and four (4) copies** of the application to the [~~Grants Accountability and Compliance Section,~~] Grants Management Bureau, Department of Public Safety, 4491 Cerrillos Road, P.O. Box 1628, Santa Fe, New Mexico 87504-1628, phone number [~~827- 9112~~] (505)827-3347.

B. The application should be single-spaced and single-sided on 8 1/2 x 11" paper. Print styles and sizes should be conducive to easy reading, i.e., no italics unless used for highlighting. The entire application packet should not exceed forty (40) pages.

C. Application deadline: All applications must be received at the [~~grants accountability and compliance section~~] grants management bureau, department of public safety no later than 5:00 P.M., [~~August 24, 2007~~] August 22, 2008. It is the responsibility of the applicant to ensure that the application is received by the [~~grants accountability and compliance section,~~] grants management bureau, department of public safety. Any application not received by the [~~grants accountability and compliance section~~] grants management bureau will not be considered once the deadline has expired.

D. Single purpose area rule: Only applications proposing to carry out a project in one single program will be accepted for funding consideration.

E. Proposed project term: The term of the project proposed in the application may exceed 12 months; however, funding beyond the initial award for 12 months is not guaranteed. Availability of limited funds restricts the state in granting award amounts on a year-to-year basis. The state recognizes that continued funding of successful projects is paramount to the success of the overall program. Projects should be designed to be consistent with the multi-year state strategy.

F. Certification requirements: Drug free workplace requirement: This applies to state agencies **ONLY.** Title V, Section 5153, of the Anti-Drug Abuse Act of 1988 provides that all state agencies receiving federal funds shall certify and submit proof to the granting agency that it will provide a drug-free workplace.

G. Debarment, suspension, ineligibility, and voluntary exclusion: All applicants for funds will be required to complete a certification stating that the applicant has not been suspended, debarred, or is otherwise ineligible to participate in this federal program.

H. Disclosure of lobbying activities requirement: Section 319 of Public Law 101-121 generally prohibits recipients of federal contracts, grants and loans from using appropriated funds for lobbying the executive or legislative branches of the federal government in connection with a specific contract, grant or loan. Section 319 also requires each person who requests or receives a federal contract, grant, cooperative agreement, loan or a federal commitment to insure or grant a loan, to disclose lobbying. The term "recipient" as used in this context does not apply to Indian tribes, organizations, or agencies.

I. Disclosure of federal participation requirement: Section 8136 of the Department of Defense Appropriations Act (Stevens Amendment) enacted in October 1988, requires that when issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs funded in whole or in part with federal money, all grantees receiving federal funds, including but not limited to state and local governments, shall clearly state (1) the percentage of the total cost of the program or project which will be financed with federal money, and (2) the dollar amount of federal funds for the project or program. This applies only to subgrantees who receive $500,000 or more in the aggregate during a single funding year.

J. General financial requirements: Grants funded under the formula grant program are governed by the provisions of 28 CFR Part 66, Common Rule, Uniform Administrative Requirements for Grants and Cooperative Agreements with State and Local Government and the Office of Management and Budget (OMB) Circulars applicable to financial assistance. These circulars along with additional information and guidance contained in "OJP financial guide for grants" (current edition), are available from OJP and from the [~~grants accountability and compliance section~~] grants management bureau. This guideline manual provides information on cost allowability, methods of payment, audits, accounting systems and financial records.

K. Audit requirement: Agencies applying for federal funds must assure that they will comply with the appropriate audit requirement. Subgrantees expending $500,000 or more in a fiscal year in all sources of federal funding shall have a single-organizationwide audit conducted in accordance with OMB Circular A-133, as amended.

L. Confidential funds requirement: State agencies and local units of government may apply for and receive grants to conduct law enforcement undercover operations. Each agency must certify that it will develop policies and procedures to protect the confidentiality of the operations. Agencies must also certify that they will comply with the office of justice programs financial guide current edition.

M. Civil rights requirement: The applicant certifies that it will comply with the non-discrimination requirements of the Omnibus Crime Control and Safe Streets Act of 1968, as amended; Title II of the Americans With Disabilities Act of 1990 42 U.S.C. 12131; Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973, as amended; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Department of Justice Nondiscrimination Regulations 28 CFR Part 35 and 42, Subparts C, D, E and G; and Executive Order 11246, as amended by Executive Order 11375, and their implementing regulations. This applicant further certifies that if a federal or state court or the administrative agency makes a finding of discrimination, it will immediately forward a copy of the finding to the grantor agency, for submission to the office of civil rights, office of justice programs, U.S. department of justice within 30 days of receipt.

[10.10.2.11 NMAC - Rp 10 NMAC 10.2.11, 3-15-00; A, 05-31-02; A, 05-28-04; A, 07-29-05; A, 07-31-07; A, 07-31-08]

10.10.2.12 ALLOWABLE/UNALLOWABLE

EXPENSES: In order to ensure the most efficient and effective use of grant funds, the Anti-Drug Abuse Act places restrictions on the use of these funds for personnel costs, construction, supplanting of applicant funds, and land acquisition.

A. Administrative expenses and indirect costs: Applicants shall limit total administrative expenses and indirect cost to no more than five percent (5%) of their grant award. The cost of operating and maintaining facilities, depreciation, and administrative salaries are examples of indirect costs. Use of more than five percent of the funds for administration of a program shall be justified and itemized in the application. The final determination shall be made by the department of public safety. In no case can administrative expenses or indirect costs exceed ten percent (10%).

B. General salaries and personnel costs: Payment of personnel costs with grant funds is permitted if the costs are part of an approved program or project (Section 501 (b) of the act). Applicants must provide a copy of their agency's overtime policy with the grant application for review and prior approval by the department of public safety prior to overtime reimbursement. General salary and personnel cost must:

(1) reflect an after-the-fact distribution of the actual activity of each employee;

(2) account for the total activity for which each employee is compensated.

C. Expenditures for purchase of services, evidence, and information (confidential funds): Formula grant funds which may be used for confidential expenditures are defined as funds used for the purchase of services, purchase of physical evidence and information, including buy money, flash rolls, etc. Guidelines related to confidential expenditures are found in OJP financial guide for grants. The [~~grants accountability and compliance section~~] grants management bureau has the authority to approve the allocation, use, and expenditure of formula subgrantee funds for confidential expenditures. **All applications containing projects which utilize funds for confidential expenditures must contain an assurance that the guidelines found in OJP financial guide for grants will be followed.**

D. Land acquisition: Acquisition of land with grant funds is prohibited (Section 505 (c) of the act).

E. Evaluation costs: Expenses associated with conducting evaluations of programs/projects funded with formula grant funds are allowable expenses and may be paid with administrative funds, program funds, or a combination of both (Sec 504 (d) of the act).

F. Audit costs: Expenses associated with conducting audits of programs/projects funded with formula grants are allowable expenses and may be paid with administrative funds, program funds, or a combination of both (sec 504 (d) of the act).

G. Non-supplantation: Formula grant funds shall not be used to supplant applicant funds, but will be used to increase the amount of such funds that would, in the absence of federal aid, be made available for law enforcement activities.

H. Participation in drug enforcement administration task forces: Formula grant funds may be used for expenses associated with participation of the state or units of local government, or combination thereof, in the state and local task force program established by the drug enforcement administration (Section 504 (c) of the act).

[10.10.2.12 NMAC - Rp 10 NMAC 10.2.12, 3-15-00; A, 07-29-05; A, 07-31-08]

10.10.2.14 APPLICATION FORMAT AND RATING CRITERIA

A. Application format:

(1) Letter of transmittal - A letter from the agency director briefly stating the purpose of the application. This letter may take any form, but it should not exceed one page in length.

(2) Application cover sheet - This standard form must accompany the application packet. (Refer to Attachment B, for a copy of this form.)

(3) Table of contents - A list of page locations for the executive summary, the various sections of the application narrative, and items in the appendix. The table of contents should list the contents of the application in the order that they appear.

(4) Executive summary - A brief description of the project, and a brief but thorough description of the problem or issue to which it is designed to respond. **Executive summaries should not exceed one page in length.**

(5) Application narrative and budget summary and detailed budget justification - Refer to attachment C for a detailed description of the format for the narrative and attachment D and D-1 for a detailed format of the budget summary and detailed budget justification. The narrative and the detailed budget justification should provide a detailed description of how the proposed project meets each of the project rating criteria. Applicants must provide a copy of their agency's overtime policy with the grant application for review and prior approval by the department of public safety prior to overtime reimbursement.

(6) Appendix - The location for attachments, forms, letters, graphs, and other pertinent information. The appendix should include, at a minimum, the following items:

(a) Letters of support, letters of commitment, joint powers agreements (JPA), memorandums of understanding (MOU), etc. Letters of support must be addressed to the cabinet secretary and included in the application; but they should not be mailed to him directly. Letters of commitment should be addressed to the head of the agency applying for the funds. JPAs and MOUs must be signed by all agencies participating in joint applications.

(b) A completed budget summary and a detailed budget justification (refer to attachment D and D-1, for these forms). New Mexico department of finance & administration expenditure line items (refer to attachment D-2) must be used in completing the budget summary and the detailed budget justification (refer to attachment D and D-1).

(c) Certified assurances (refer to attachment E for a copy of this form).

(d) Any other items which you believe are pertinent to the application process and which only address information requested in this rule.

B. Rating criteria (total value - 100 points) - The rating will be based on the oral presentations and must follow the format of the application submitted as set forth in 10.10.2.14 NMAC. Applicable program purpose areas [(refer to attachment A):]

C. Application narrative - utilize the rating criteria (refer to attachment C) to develop the narrative by responding to the questions under each of following sections:

(1) projected impact;

(2) project design and performance;

(3) prior performance;

(4) complete the applicable section pertaining to your program purpose area:

(a) multi-jurisdictional task forces; or

(b) other program purpose areas.

D. Budget summary and detailed budget justification.

(1) Provide a detailed budget justification narrative (attachment D-1) on proposed expenditures and revenue sources for the federal grant funds being requested and the match funds which will be provided. Use the New Mexico department of finance and administration (DFA) **line item codes** (attachment D-2).

(2) Complete the **budget summary** sheet (attachment D) and make reference to it in the detailed budget justification narrative.

[10.10.2.14 NMAC - Rp 10 NMAC 10.2.14, 3-15-00; A, 05-31-02; A, 05-28-04; A, 07-29-05; A, 07-31-08]

10.10.2.15 SELECTION PROCESS: The department of public safety will make a decision on each complete application within 45 days of receipt. An applicant shall be deemed approved by the state unless the state informs the applicant in writing within 45 days of the specific reason for disapproval. The state shall not disapprove any application without first affording the applicant reasonable notice and opportunity for reconsideration (Sec 508 (a) of the act). The failure of an application to conform to state program priorities or to meet criteria set forth in this document may constitute reason for disapproval. The selection process is as follows:

A. Upon receipt of applications, the [~~grants accountability and compliance section~~] grants management bureau staff will review the applications for eligibility, completeness, and compliance. The [~~grants accountability and compliance section~~] grants management bureau staff will then schedule the eligible applicants for oral presentations before the selection panel.

B. Eligible applications will be forwarded to a panel for review and use during the oral presentations conducted for applicants. The selection panel through the [~~grants accountability and compliance section~~] grants management bureau will submit their recommendations for consideration to the cabinet secretary.

C. The cabinet secretary of the department of public safety has the final authority in the awarding of grants.

D. Unsuccessful applications may appeal if the applicant feels any federal or state regulation involving selection was violated. A three-member appeal panel shall review the alleged violation, decide on its validity, and make a recommendation to the cabinet secretary of the department of public safety. The cabinet secretary's decision shall be final.

[10.10.2.15 NMAC - Rp 10 NMAC 10.2.15, 3-15-00; A, 05-28-04; A, 07-29-05; A, 07-31-08]

NEW MEXICO WATER TRUST BOARD

19.25.10 NMAC, Review and Eligibility of Proposed Water Projects (filed 9/3/2002), is repealed and replaced by 19.25.10 NMAC, Review and Eligibility of Proposed Water Projects, effective 7/31/08.

NEW MEXICO WATER TRUST BOARD

TITLE 19 NATURAL RESOURCES AND WILDLIFE
CHAPTER 25 ADMINISTRATION AND USE OF WATER-GENERAL PROVISIONS
PART 10 REVIEW AND ELIGIBILITY OF PROPOSED WATER PROJECTS

19.25.10.1 ISSUING AGENCY: New Mexico Water Trust Board.
[19.25.10.1 NMAC - Rp, 19.25.10.1 NMAC, 7/31/08]

19.25.10.2 SCOPE: All persons applying for financial assistance under the water project fund from the New Mexico finance authority, NMSA 1978, 72-4A-5 and NMSA 1978, 72-4A-9.
[19.25.10.2 NMAC - Rp, 19.25.10.2 NMAC, 7/31/08]

19.25.10.3 STATUTORY AUTHORITY: NMSA 1978, 72-4A-5 and NMSA 1978, 72-4A-9.
[19.25.10.3 NMAC - Rp, 19.25.10.3 NMAC, 7/31/08]

19.25.10.4 DURATION: Permanent.
[19.25.10.4 NMAC - Rp, 19.25.10.4 NMAC, 7/31/08]

19.25.10.5 EFFECTIVE DATE: July 31, 2008, unless a later date is cited at the end of a section.
[19.25.10.5 NMAC - Rp, 19.25.10.5 NMAC, 7/31/08]

19.25.10.6 OBJECTIVES:

A. Section 72-4A-5, NMSA 1978 provides that the New Mexico water trust board is required to adopt rules governing terms and conditions of grants and loans recommended by the board for appropriation by the state legislature from the water project fund giving priority to projects that have urgent needs, that have been identified for implementation of a completed regional water plan that is accepted by the interstate stream commission and that have matching contributions from federal or local funding sources; and authorizes qualifying water projects to the authority that are for: (1) storage, conveyance or delivery of water to end users; (2) implementation of federal Endangered Species Act of 1973; (3) restoration and management of watersheds; (4) flood prevention; and (5) conservation, recycling, treatment or reuse of water as provided by law. Additionally, the board shall create a drought strike team to coordinate responses to emergency water shortages caused by drought conditions. Section 72-4A-9, NMSA 1978, creates the "water project fund" within the New Mexico Finance Authority.

B. Section 72-4A-5, NMSA 1978, provides that the board shall give priority to qualifying water projects that (i) have been identified as being urgent to meet the needs of a regional water planning area that has had a completed regional water plan accepted by the interstate stream commission; (ii) have matching contributions from federal or local funding sources available and (iii) have obtained all requisite state and federal permits and authorizations necessary to initiate the qualifying water project. The purpose of these rules is to set forth the intent of the board and to outline, in general terms, the criteria and procedures to be used in evaluating and funding qualifying water projects.

C. Section 72-4A-6, NMSA 1978, provides that the authority shall provide support for the water trust board, develop application procedures and forms for qualifying entities to apply for grants and loans from the water project fund; and make loans or grants to qualifying entities for qualifying water projects authorized by the state legislature, provided that the service area for the project is wholly within the boundaries of the state or the project is an interstate project that directly benefits New Mexico.

D. Section 72-4A-9, NMSA 1978, provides that the authority may adopt separate procedures and rules for administration of the water project fund and recover from the water project fund costs of administering the water project fund and originating grants and loans.

[19.25.10.6 NMAC - Rp, 19.25.10.6 NMAC, 7/31/08]

19.25.10.7 DEFINITIONS:

A. "Act" means the Water Project Finance Act, Sections 72-4A-1 through 72-4A-10, NMSA 1978, as the same may be amended and supplemented.

B. "Agreement" means the document or documents signed by the board and a qualifying entity which specify the terms and conditions of obtaining financial assistance from the water project fund.

C. "Applicant" means a qualifying entity which has filed a water project proposal with the authority for initial review and referral to the board's project review committee.

D. "Authority" means the New Mexico finance authority.

E. "Authorized representative" means one or more individuals duly authorized to act on behalf of the qualifying entity in connection with its financial application, water project proposal or agree-

ment.

F. "Board" means the New Mexico water trust board created by the act.

G. "Bylaws" means the bylaws of the board adopted on September 25, 2001, and amended on June 27, 2007, and as may be further amended and supplemented.

H. "Financial application" means a written document filed with the authority by an applicant for the purpose of evaluating the applicant's qualifications for types of financial assistance which may be provided by the board.

I. "Financial assistance" means loans, grants and any other type of assistance authorized by the act, or a combination thereof, provided from the water project fund to a qualified entity for the financing of a qualifying water project.

J. "Political subdivision" means a municipality, county, irrigation district, conservancy district, special district, acequia or soil and water conservation district, water and sanitation district, or an association organized and existing pursuant to the Sanitary Projects Act, Chapter 3, Article 29 NMSA 1978.

K. "Project review committee" means a standing committee, appointed by the chairman of the board from the members of the board pursuant to the bylaws to review water projects to be recommended for funding from the water project fund.

L. "Qualifying entity" means a state agency, a political subdivision of the state or a recognized Indian nation, tribe or pueblo, the boundaries of which are located wholly or partially in New Mexico.

M. "Qualifying water project" means a project recommended by the board for funding by the legislature which includes a water project serving an area wholly within the boundaries of the state for (i) storage, conveyance or delivery of water to end users; (ii) implementation of federal Endangered Species Act of 1973 collaborative programs; (iii) restoration and management of watersheds; (iv) flood prevention; or (v) conservation, recycling, treatment or reuse of water as provided by law and which has been approved by the state legislature pursuant to Section 72-4A-9(B), NMSA 1978.

N. "State" means the state of New Mexico.

O. "State agency" means any agency or institution of the state.

P. "Water project account" means a fund designated by a qualifying entity exclusively for receipt of financial assistance.

Q. "Water project fund" means the fund of that name created in the authority by Section 72-4A-9, NMSA 1978.

R. "Water project proposal" means a written proposal submitted by a qualifying entity for review by the project review committee.

S. "Water trust fund" means the fund of that name created in the state treasury by Section 72-4A-8, NMSA 1978.

[19.25.10.7 NMAC - Rp, 19.25.10.7 NMAC, 7/31/08]

19.25.10.8 ELIGIBILITY: PRIORITIZATION OF WATER PROJECTS: The board will develop and consider a variety of factors in reviewing and evaluating water project proposals to determine which water projects to recommend as qualifying water projects for appropriation by the state legislature. The board shall give priority to projects that have urgent needs, that have been identified for implementation of a completed regional water plan that is accepted by the interstate stream commission and that have matching contributions from federal or local sources as provided for in Section 72-4A-5, NMSA 1978. Pursuant to Section 72-4A-5.1, NMSA 1978, the board, in conformance with the state water plan and pursuant to the provisions of the Water Project Finance Act, shall prioritize the planning and financing of water projects required to implement the plan. The board shall identify opportunities to leverage federal and other funding. The board shall establish policies for prioritization of water projects.

[19.25.10.8 NMAC - Rp, 19.25.10.8 NMAC, 7/31/08]

19.25.10.9 WATER PROJECT PROPOSAL, PROCEDURES AND APPROVAL PROCESS:

A. The board and the authority will administer an outreach program to notify qualifying entities that water project proposals are being accepted to identify water projects for review by the project review committee and the board for recommendation for funding to the state legislature as qualifying water projects.

B. The authority will provide forms and/or guidelines for water project proposals and financial applications.

C. The authority staff will forward all completed water project proposals and the initial evaluation of financial applications and water project proposals to the project review committee. The project review committee will consider the water project and may confer with outside parties, including any local interdisciplinary teams familiar with the water project, as necessary to obtain more information on the feasibility, merit, and cost of the water project. The project review committee will make a recommendation to the board on each water project proposal.

D. Upon the recommendation of the project review committee, the board will prioritize the qualifying water projects for recommendation to the legislature.

E. After completion of the review process by the project review committee and the board and receipt of a favorable recommendation on the water project proposal, the water project will be recommended by the board for approval by the state legislature, which recommendation and approval are required by Sections 72-4A-5 and 72-4A-9, NMSA 1978.

F. No later than January of each year, the board will recommend to the legislature a final list of projects recommended for funding. After the legislature authorizes qualifying water projects, the project review committee will recommend to the board a list of projects to be authorized by the board for funding by the authority. The authority will provide financial assistance for qualifying projects as authorized by the legislature under policies jointly established by the board and authority.

[19.25.10.9 NMAC - Rp, 19.25.10.9 NMAC, 7/31/08]

19.25.10.10 EVALUATION OF FINANCIAL APPLICATION AND WATER PROJECT PROPOSAL: The authority staff will complete an initial evaluation of the financial application and water project proposal upon receipt. Such evaluation will include, to the extent applicable, an evaluation of water project feasibility, administrative capacity, financial position, debt management and economic and demographic factors. The authority may rely upon the advice of an interdisciplinary team in evaluating water project proposals and financial applications.

[19.25.10.10 NMAC - Rp, 19.25.10.10 NMAC, 7/31/08]

19.25.10.11 QUALIFYING WATER PROJECTS AND ELIGIBLE COSTS:

A. The board may authorize the authority to provide financial assistance from the water project fund to qualifying entities only for qualifying water projects as provided by Section 72-4A-6 and Section 72-4A-7, NMSA 1978.

B. Financial assistance shall be made only to qualify entities that:

(1) agree to operate and maintain the water project so that it will function properly over the structural and material design life, which shall not be less than twenty years;

(2) require the contractor of the construction project to post a performance

and payment bond in accordance with the requirements of Section 13-4-18, NMSA 1978;

(3) provide written assurance signed by an attorney or provide a title insurance policy that the political subdivision has proper title, easements and rights of way to the property upon or through which the water project proposed for funding is to be constructed or extended;

(4) meet the requirements of the financial capability set by the board to ensure sufficient revenues to operate and maintain the water project for its useful life and to repay the loan;

(5) agree to properly maintain financial records and to do an audit of the project's financial records; and

(6) agree to pay costs of originating grants and loans as determined by rules adopted by the board.

C. Plans and specifications for a water project shall be approved by the authority before grant or loan disbursement to pay for construction costs is made to a qualifying entity. Plans and specifications for a water project shall incorporate available technologies and operations design for water efficiency.

D. Financial assistance shall be made for eligible items, which include:

(1) matching requirements for federal and local cost shares;

(2) engineering feasibility reports;

(3) contracted engineering design;

(4) inspection of construction;

(5) special engineering services;

(6) environmental or archeological surveys;

(7) construction;

(8) land acquisition;

(9) easements and rights of way; and

(10) legal costs and fiscal agent fees.

E. A qualified entity which has had financial assistance approved by the state legislature for financing a qualifying water project may apply to the board to redirect the financial assistance to a different water project made necessary by unanticipated events. The decision to redirect the financial assistance to a different qualifying water project will be at the sole discretion of the board and subject to approval of the state legislature as required by Section 72-4A-9(B), NMSA 1978.

[19.25.10.11 NMAC - Rp, 19.25.10.11 NMAC, 7/31/08]

19.25.10.12 QUALIFYING WATER PROJECT FINANCING: The authority may recommend structured financial assistance packages that include loans, grants and any other type of assistance authorized by the authority. The structure, terms and conditions of the financial assistance will be determined by the authority and approved by the board. Financial assistance for qualifying water projects may be pooled, at the sole discretion of the authority, under policies jointly established by the board and authority.

[19.25.10.12 NMAC - Rp, 19.25.10.12 NMAC, 7/31/08]

19.25.10.13 FINANCING APPROVAL REQUIREMENTS: Based on the priority and evaluation factors set forth in Sections 19.25.10.8, 19.25.10.10, and 19.25.10.11, the board may recommend to the authority approval of the qualifying water project for financial assistance.

[19.25.10.13 NMAC - Rp, 19.25.10.13 NMAC, 7/31/08]

19.25.10.14 APPEALS: Any applicant or qualified entity may appeal a decision of the board by notifying the board in writing within forty-five days of the date on which notice of an adverse decision is given by the board to an applicant. Notice is deemed to be given on the fifth business day following the date on which written notice is mailed to the applicant by the board by U.S. mail. Appeals not timely or properly made will be barred thereafter. The chairman of the board will promptly review each timely appeal and will recommend, at the next regular meeting of the board, action to be taken by the board on the appeal. The board will review and take action on the appeal and will notify the applicant or qualified entity of the board's decision, in writing, within five working days of the board's decision. The decision of the board is final.

[19.25.10.14 NMAC - Rp, 19.25.10.14 NMAC, 7/31/08]

19.25.10.15 FINANCIAL ASSISTANCE AGREEMENT:

A. The board and the qualified entity will enter into an agreement to establish the terms and conditions of financial assistance from the board. The agreement will include the terms of repayment and remedies available to the board in the event of a default. The board, or the authority, on behalf of the board, will monitor terms of the agreement and enforce or cause to be enforced all terms and conditions thereof, including prompt notice and collection.

B. The interest on any financial assistance extended shall be determined by the authority based on the cost of funds and ability of a qualified entity to repay a loan. The interest rate shall not change during the term of the financial assistance unless refinanced or unless the financial assistance is structured as a variable rate obligation.

C. The agreement will contain provisions which require financial assistance recipients to comply with all applicable federal, state and local laws and regulations.

D. In the event of default under a financial assistance agreement by a qualified entity, the board, or the authority, on behalf of the board, may enforce its rights by suit or mandamus and may utilize all other available remedies under state and applicable federal law.

[19.25.10.15 NMAC - Rp, 19.25.10.15 NMAC, 7/31/08]

19.25.10.16 ADMINISTRATIVE COSTS:

A. The board may impose and collect reasonable fees and costs in connection with the filing of a water project proposal or a financial application for approval of a water project and for financial assistance with the board and the authority. The board also may impose and collect an administrative fee from each qualifying entity that receives financial assistance from the water project fund. If an administrative fee is assessed, the administrative fee will be a percentage of the principal amount of the financial assistance provided to a qualifying entity. The administrative fee may be withheld from the principal amount of the financial assistance and will be retained in the water project fund. Alternatively, the board may levy an annual fee equal to a percentage of the outstanding principal amount of a loan. Specific percentages will be based on, among other things, the volume of financial assistance being provided to qualifying entities, the administrative costs of the board and the authority, and the availability of other revenue sources to cover the board's and the authority's administrative costs. The filing and administrative fee or fees may be used for, among other purposes, reimbursing the board or the authority for all or part of the costs of issuing bonds and other administrative costs, including any audits of the water project fund and the water trust fund.

B. The board and the authority may establish such other charges, premiums, fees and penalties deemed necessary for the administration of the water project fund and the water trust fund.

[19.25.10.16 NMAC - Rp, 19.25.10.16 NMAC, 7/31/08]

19.25.10.17 ADMINISTRATION OF THE WATER TRUST FUND:

A. The water trust fund shall be administered by the state treasurer's office and shall be invested by the state investment officer in the same manner as land grant permanent funds are invested under state law. All investment earnings on

the water trust fund shall be credited to the water trust fund. The water trust fund shall not be expended for any purpose.

B. Annual distributions to the water project fund from the water trust fund shall be made as required by the authority.

[19.25.10.17 NMAC - Rp, 19.25.10.17 NMAC, 7/31/08]

19.25.10.18 ADMINISTRATION OF THE WATER PROJECT FUND:

A. The water project fund shall be administered by the authority as a separate account, but may consist of such subaccounts as the authority deems necessary to carry out the purposes of the fund.

B. Money from repayments of loans made by the board for qualifying water projects shall be deposited in the water project fund. The water project fund shall also consist of any other money appropriated, distributed or otherwise allocated to the water project fund for the purpose of financing qualifying water projects.

C. The authority shall adopt a uniform accounting system for the water project fund and each account and subaccount established by the authority, based on generally accepted accounting principles.

D. The authority may establish procedures and adopt rules as required to administer the fund and to recover from the fund costs of administering the fund and originating grants and loans.

[19.25.10.18 NMAC - Rp, 19.25.10.18 NMAC, 7/31/08]

19.25.10.19 BOND ISSUANCE:

A. The authority may issue and sell revenue bonds as required to provide funds to:

(1) replenish the principal balance of the water project fund;

(2) pay, fund or refund the principal of or interest or redemption premiums, if any, on bonds issued by the authority whether the bonds or interest to be paid, funded or refunded have or have not become due;

(3) establish or increase reserve funds to secure bonds; and

(4) pay the costs and expenses incident to the issuance of bonds.

B. The authority will consider market and other economic conditions in determining the type of sale and the timing of the issuance of bonds.

C. The bonds shall be authorized and issued by the authority in accordance with the provisions of the New Mexico Finance Authority Act, Chapter 6, Article 21, NMSA 1978.

[19.25.10.19 NMAC - Rp, 19.25.10.19 NMAC, 7/31/08]

19.25.10.20 AMENDMENT OF RULES: This rule may be amended or repealed at any time by a majority vote of a quorum of the board.

[19.25.10.20 NMAC - Rp, 19.25.10.20 NMAC, 7/31/08]

HISTORY OF 19.25.10 NMAC:

Pre-NMAC History: None.

History of Repealed Material:

19.25.10 NMAC, Review and Eligibility of Proposed Water Projects (filed 9/3/2002) repealed 7/31/08.

NMAC History:

19.25.10 NMAC, Review and Eligibility of Proposed Water Projects (filed 9/3/2002) was replaced by 19.25.10 NMAC, Review and Eligibility of Proposed Water Projects, effective 7/31/08.

End of Adopted Rules Section

SUBMITTAL DEADLINES AND PUBLICATION DATES

2008

Volume XIX	Submittal Deadline	Publication Date
Issue Number 1	January 2	January 15
Issue Number 2	January 16	January 31
Issue Number 3	February 1	February 14
Issue Number 4	February 15	February 29
Issue Number 5	March 3	March 14
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Issue Number 7	April 1	April 15
Issue Number 8	April 16	April 30
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Issue Number 23	December 2	December 15
Issue Number 24	December 16	December 31

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