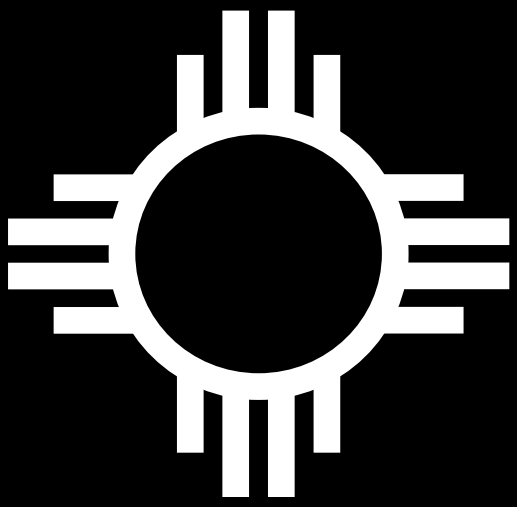
NEW MEXICO REGISTER



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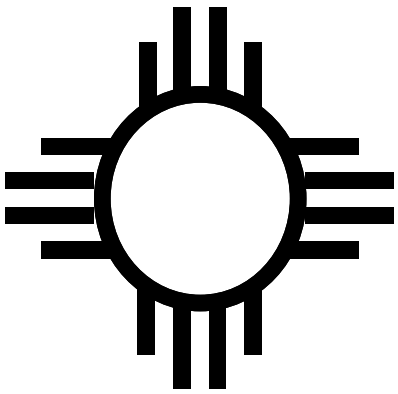

The official publication for all notices of rulemaking and filings of adopted, proposed and emergency rules in New Mexico

The Commission of Public Records
Administrative Law Division
Santa Fe, New Mexico
2005

New Mexico Register

Volume XVI, Number 12
June 30, 2005

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Effective Date and Validity of Rule Filings

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

A=*Amended*, E=*Emergency*, N=*New*, R=*Repealed*, Rn=*Renumbered*

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

Notices of Rulemaking and Proposed Rules

NEW MEXICO ECONOMIC DEVELOPMENT DEPARTMENT

OPEN MEETING NOTICE

Chairwoman Kathy Keith has announced that a Monthly Board Meeting for the Industrial Training Board will be held as scheduled:

DATE: Friday, July 22, 2005
JTIP Board Meeting
8:30 a.m. to 11:00 a.m.

JTIP Policy Making Meeting
11:00 a.m. to 2:00 p.m.
(For Board & Staff Members Only)

LOCATION: Santa Fe Business Incubator
Conference B
3900 Paseo del Sol
Santa Fe, NM 87507

Phone number: (505) 424-1140

PURPOSE: To review the Job Training Incentive Program's proposals, fiscal update and the Board will revise its policies (Title 5, Chapter 5, Part 50).

The Board will address and possibly take action on any other issues related to the Job Training Program

For additional information, including a meeting agenda, please contact Therese R. Varela at (505) 827-0323. If you are disabled and require assistance, auxiliary aids and services, (Voice & TDD), and/or alternate formats in order to further your participation, please contact Cynthia Jaramillo, ADA Coordinator at (505) 827-0248. These individuals are employees of New Mexico Economic Development Department, 1100 St. Francis Dr., Santa Fe, NM 87505-4147.

NEW MEXICO ENERGY, MINERALS AND NATURAL RESOURCES DEPARTMENT

ENERGY CONSERVATION AND MANAGEMENT DIVISION

NOTICE OF PUBLIC MEETING AND HEARING OF THE NEW MEXICO ENERGY, MINERALS AND NATURAL RESOURCES DEPARTMENT

The New Mexico Energy, Minerals and Natural Resources Department will hold a meeting and hearing at **9:00 A.M. Monday, July 18, 2005** in Porter Hall, first floor, 1220 South Saint Francis Drive, Santa Fe, NM.

During the meeting, the New Mexico Energy, Minerals and Natural Resources Department will conduct a public hearing on proposed changes to rule 3.13.19 NMAC for administration of the Renewable Energy Production Tax Credit, NMSA 1978, Section 7-2A-19 as amended in 2005 by HB 950. In addition, a proposed change would raise the limit of a facility's eligible energy production from the estimated average annual production to the estimated annual production potential.

Copies of the rules and the proposed changes are available from the New Mexico Energy, Minerals and Natural Resources Department, Energy Conservation and Management Division, 1220 South Saint Francis Drive, Santa Fe, NM 87505, on our website, http://www.emnrd.state.nm.us/ecmd/, or by contacting Michael McDiarmid at 505-476-3319, michael.mcdiarmid@state.nm.us or Harold Trujillo at 476-3318, harold.trujillo@state.nm.us.

All interested persons may participate in the hearing, and will be given an opportunity to submit relevant evidence, data, views, and arguments, orally or in writing.

A person who wishes to submit a written statement, in lieu of providing oral testimony at the hearing, shall submit the written statement prior to the hearing, or submit it at the hearing. No statements will be accepted after the conclusion of the hearing.

If you are an individual with a disability who is in need of a reader, amplifier, qualified sign language interpreter, or any other form of auxiliary aid or service to attend or participate in the hearing, please contact Michael McDiarmid at least one week prior to the hearing or as soon as possible. Public documents can be provided in various accessible formats. Please contact Michael McDiarmid at 476-3319, through Relay New Mexico at 1-800-659-1779 Voice or 1-800 659-8331 TTY, if a summary or other type of accessible format is needed.

NEW MEXICO ENVIRONMENTAL IMPROVEMENT BOARD

NEW MEXICO ENVIRONMENTAL IMPROVEMENT BOARD
NOTICE OF PUBLIC MEETING AND HEARING

Proposed Revision of 7.6.2.8(K) NMAC - Proposed Amendments to the Food Service and Food Processing Permit Fees Regulations (EIB 05-08 (R))

The New Mexico Environmental Improvement Board (Board) will hold a public hearing on October 4, 2005, in conjunction with their normal October meeting. The hearing will begin at 9:30 a.m. at the New Mexico State Capitol Building, Room 321 in Santa Fe, New Mexico. At this hearing, the Board will consider proposed revisions to 7.6.2.8 (K) NMAC –Food Service and Food Processing Permit Fees Regulations **EIB 05-08(R).**

The purpose of the public hearing is to consider and take possible action on a petition from the New Mexico Environment Department (NMED) Field Operations Division regarding proposed revisions to NMAC 7.6.2.8 (K). The Field Operations Division proposes to amend only Section 8(K) of the Food Service and Food Processing rules in accordance with changes mandated by the New Mexico Legislature through the recent passage and signing of HB 455 of the 47th Legislature, First Session. According to HB 455, the Food Service Sanitation Act was amended to raise permit fees. The Food Service Sanitation Act authorizes the EIB to establish a schedule of fees for the issuance and renewal of permits issued by NMED. The Field Operations Division of NMED proposes amendments to the schedule of fees in 7.6.2.8 (K) NMAC in accordance with the recently amended Food Service Sanitation Act.

The proposed changes may be reviewed during regular business hours at the NMED Field Operations Division office located at 525 Camino De Los Marquez, Suite 1, Santa Fe, New Mexico. A full text of the NMED's proposed changes are also available on the NMED's web site at www.nmenv.state.nm.us, or by contacting Barbara Kitay by phone at (505) 827-1400 ext. 1003 or by e-mail at Barbara_Kitay@nmenv.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, 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 changes.

Notices of intent for the hearing must be received in the Office of the Environmental Improvement Board not later than **5:00 pm on Monday, September 19th, 2005**, and should reference the name of the NMAC 7.6.2.8(K) revision and the date of the hearing, October 4th , 2005. Notices of intent to present technical testimony should be submitted to:

Barbara Claire, 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 Monday, September 19th , 2005 at the New Mexico Environment Department, 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 deliberate and rule on the proposed amendments at the close 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 RULE MAKING NOTICE

On Thursday, July 7, 2005, beginning at 9:00 a.m. at the Catron County Courthouse, 100 Main Street, Reserve, NM 87830, the State Game Commission will meet in Public Session to consider action as appropriate on the following: Consent Agenda for Revocation of Hunting and Fishing License Privileges; Draft Comprehensive Wildlife Conservation Strategy; Private Land Entry and Sportsmen Enjoyment (P.L.E.A.S.E.) Pilot Program Update; Process for Appointment of the Citizen Advisory Committee for the Habitat Improvement Stamp Program in Accordance with 17-2-1, NMSA; Native Trout Restoration Techniques on Gila River West Fork and Rio Costilla Watershed; Elk Management in Game Management Unit 10; Mexican Gray Wolf Reintroduction Update; Annual Depredation Report and Overview of New Approaches; General Public Comments; and Closed Executive Session to discuss litigation, personnel, and acquisition or disposal of real property or water rights, and pursuant to Section 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 unidentified individual(s) that may have violated their professional code of conduct as per 19.30.8 and 19.31.2 NMAC.

The following rules are open for amendment or adoption by the Commission:

* Change to Fishing Regulation 19.31.4 NMAC, on Comanche Creek to restrict to catch and release only;
* Adoption of Upland Game Rule, 19.31.5 NMAC, regarding season dates and bag limits for 2005-2006 license year only (see Department website); and
* Adoption of Waterfowl Rule, 19.31.6 NMAC, regarding season dates and bag limits for 2005-2006 license year only (see Department website).

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, qualified 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) 476-8030. 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 GAMING CONTROL BOARD

NEW MEXICO GAMING CONTROL BOARD

NOTICE OF HEARING ON AMENDMENTS TO RULES

The New Mexico Gaming Control Board ("Board") will hold a public hearing at 9:00 a.m. on August 2, 2005 , at the New Mexico Gaming Control Board, 4900 Alameda Blvd., N.E., Albuquerque, New Mexico 87113-1736 to consider amendments for the following rules: **15.4.1 NMAC,** *Bingo General,* **15.4.2 NMAC,** *Bingo Controls,* **15.4.3 NMAC,** *Bingo Licenses,* **15.4.4 NMAC,** *Bingo Reporting,* **15.4.6 NMAC,** *Bingo Penalties,* **15.4.7 NMAC,** *Premises,* **15.4.8 NMAC,** *Raffle Tickets,* **15.4.9 NMAC,** *Pull Tabs.*

Copies of the proposed amendments are available on request to the New Mexico Gaming Control Board, 4900 Alameda Blvd., N.E., Albuquerque, New Mexico 87113-1736, or by calling (505) 841-9733. The proposed changes are also available on our website at www.nmgcb.org. The Board can provide public documents in various accessible formats.

The hearing will be held before a hearing officer appointed by the Board. All interested parties may attend the hearing and present their views orally or submit

written comments prior to the hearing. Written comments should be directed to the Gaming Control Board, Attn, Legal Division, 4900 Alameda Blvd., N.E., Albuquerque, New Mexico 87113-1736.

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

NEW MEXICO HIGHER EDUCATION DEPARTMENT

NOTICE OF PROPOSED RULEMAKING

The New Mexico Higher Education Department will convene a public hearing on Wednesday, July 6, 2005 from 8:00 a.m. to 5:00 p.m. Final actions on the proposed rulemaking will be taken at that meeting, which will be held at the New Mexico School for the Deaf, in the Pat Payne Conference Room, 1064 Cerrillos Road, Santa Fe, NM 87505. Information regarding the location of the meetings, the addition or change of meeting days, and the agenda for the meeting, will be available at least twenty-four hours prior to the meeting from the Higher Education Department staff at 505-476-6500 and on our website at http://hed.state.nm.us. Please contact the Higher Education Department at 505-476-6500 for additional information. The Higher Education Department may consider the following items of rulemaking at the meeting:

Rule Number	Rule Name	Proposed Action
5.1.3 NMAC	POST SECONDARY EDUCA TION, POST SECONDARY EDUCATION - GENERAL PROVISIONS, FEDERAL PROGRAM ADMINISTRATI ON	Amend rule
5.3.7 NMAC	POST SECONDARY EDUCA TION, POST SECONDARY EDUCATION INSTITUTI ON FINANCES, BUILD ING AND IMPROVEMENT BONDS	Amend rule
5.3.9 NMAC	POST SECONDARY EDUCA TION, POST SECONDARY EDUCATION INSTITUTI ON FINANCES, CAPITAL BU DGETS - PLANNING AND FUNDIN G RECOMMENDATIONS	Amend rule
5.3.12 NMAC	POST SECONDARY EDUCA TION, POST SECONDARY EDUCATION INST ITUTION FINANCES, INSTRUCTIO NAL FUNDING	Amend rule
5.3.13 NMAC	POST SECONDARY EDUCA TION, POST SECONDARY EDUCATION INSTITUTIONAL FINANC ES, ALLOCATION AND D ISTRIBUTION OF THE A DULT BASIC EDUCATION FUND	Amend rule
5.6.2 NMAC	POST SECONDARY EDUCA TION, POST S ECONDARY ENROLLMENT AND DATA REPORTING, ENROLLMEN T REPORTING	Amend rule
5.6.3 NMAC	POST SECONDARY EDUCA TION, POST SECONDARY ENROLLMENT AND DATA REPORTING, VARIABLE SCHEDULING	Amend rule
5.6.4 NMAC	POST SECONDARY EDUCA TION, POST SECONDARY ENROLLMENT AND D ATA REPORTING, ENROLLMEN T VERIFICATION	Amend rule
5.7.3 NMAC	POST SECONDARY EDUCA TION, TUITION AND FI NANCIAL AID, HEALTH PROFESSIONALS LOAN R EPAYMENT	Amend rule
5.7.16 NMAC	POST SECONDARY EDUCA TION, TUITION AND FI NANCIAL AID, VIETNAM VETERANS' SCHOLARSHI P	Amend rule
5.7.19 NMAC	POST SECONDARY EDUCA TION, TUITION AND FI NANCIAL AID, REDUCED TUITION FOR SENIOR C ITIZENS	Amend rule
5.7.30 NMAC	POST SECONDARY EDUCA TION, TUITION AND FI NANCIAL AID, PROCEDU RES, STANDARDS, AND ELIGI BILITY REQUIREMENTS FOR PARTICIP ATION IN NM EDUCATION TRUST	Amend rule
5.100.2 NMAC	POST SECONDARY EDUCA TION, PRIVATE INSTIT UTIONS OF HIGHER EDUCATION, PRIVATE P OST SECONDARY INSTIT UTIONS OPERATING UND ER POST SECONDARY EDUCA TIONAL INSTITUTION A CT	Amend rule
5.100.3 NMAC	POST SECONDAR Y EDUCATION, PRIVATE INSTITUTIONS OF HIG HER EDUCATION, PRIVATE P OST SECONDARY INSTIT UTIONS OPERATING UND ER THE OUT-OF-STATE PROPRIETARY SC HOOL ACT	Amend rule

Copies of the proposed rule changes may be obtained from the Higher Education Department. Written comments concerning the rules should be submitted to Ms. Katherine B. Cantrell, Interim Secretary, 1068 Cerrillos Road, Santa Fe, NM 87505, by facsimile at (505) 476-6511, or via electronic mail at kcantrell@che.state.nm.us. Comments will be accepted until 5 p.m. on July 5, 2005; however, submission of written comments as soon as possible is encouraged.

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, please contact the Higher Education Department at (505) 476-6500 at least one week prior to the meeting, or as soon as

possible.

Comments, questions, or requests for copies of the agenda should be directed to the Higher Education Department, 1068 Cerrillos Road, Santa Fe, NM 87505, 505-476-6500 or fax 505-476-6511.

NEW MEXICO INFORMATION TECHNOLOGY COMMISSION

STATE OF NEW MEXICO
INFORMATION TECHNOLOGY COMMISSION

IN THE MATTER OF
REPEALING 1.12.5 NMAC,
"OVERSIGHT OF PROJECT AND PROGRAM MANAGEMENT AND CERTIFICTION",
RENAMING AND PROPOSING FOR ADOPTION 1.12.5 NMAC,
"OVERSIGHT OF INFORMATION TECHNOLOGY PROJECTS"

NOTICE OF PROPOSED REPEAL, RENAMING AND RULEMAKING AND PROCEDURAL ORDER

I. SOLICITATION OF COMMENTS

The Information Technology Commission ("Commission") issues this Notice of Proposed Repeal, Renaming and Rulemaking and Procedural Order to provide an opportunity for public comment and to create a record for a decision on proposing the repeal, renaming and adoption of a new rule: 1.12.5 NMAC, "Oversight of Information Technology Projects" for adoption. The Commission requests written comments from all interested persons and entities on the proposed new rule.

II. ORDER

IT IS THEREFORE ORDERED that this Notice of Proposed Repeal, Renaming and Rulemaking and Procedural Order ("Notice") be issued.

IT IS FURTHER ORDERED that all interested parties may file written comments on the repeal, renaming and proposed rule on or before July 25, 2005. All relevant and timely comments, including data, views, or arguments will be considered by the Commission before final action is taken in this proceeding. Written comments must be filed prior to the deadline for receipt of comments either in hard copy with the Chief Information Officer, Office of the Chief Information Officer, 404 Montezuma, Santa Fe, NM 87501 or by electronic mail to the Chief Information Officer at cio@state.nm.us. The rule number must appear on each submittal. Comments will be available for public inspection during regular business hours in the Office of the Chief Information Officer, 404 Montezuma, Santa Fe, NM 87501.

PLEASE BE ADVISED that the Office of the Chief Information Officer ("Office") shall review all comments for compliance with the State information architecture and the State strategic plan, prepare a summary of all comments received before the deadline, and report its findings and recommendation to the Commission. The Commission shall consider the comment draft of the proposed rule, the summary of comments, and the findings and recommendations of the Office at a meeting held after the comment period. The Commission may adopt without revision, revise and adopt, revise and seek additional comments, or reject the proposed repeal, renaming and adoption of the new rule at the public meeting to be held on Tuesday, August 16, 2005 at 8:30am in the New Mexico State Capitol Building, Room 307, Santa Fe, NM.

IT IS FURTHER ORDERED that the Commission may modify the dates and procedures if necessary to provide for a fuller record and a more efficient proceeding.

IT IS FURTHER ORDERED that staff of the Office of the Chief Information Officer shall cause a copy of this Notice to be published once in the New Mexico *Register,* once in the *Albuquerque Journal*, and to be posted to the Internet at http://www.cio.state.nm.us all on or before June 30, 2005. To obtain a copy of the proposed rule: (1) send the rule name, rule number, and a self-addressed envelope to the Office of the Chief Information Officer, 404 Montezuma, Santa Fe, NM 87501; (2) call the Office of the Chief Information Officer at 505-476-0400 with the rule name and rule number; e-mail the Chief Information Officer at cio@state.nm.us with the rule name and rule number (you will receive a copy of the rule in Microsoft WORD format by return e-mail); or download the proposed rule from the Internet at http://www.cio.state.nm.us . The proposed rule is also available for inspection and copying during regular business hours in the Office of the Chief Information Officer, 404 Montezuma, Santa Fe, NM 87501.

PLEASE BE ADVISED THAT individuals with a disability who are in need of summaries or other types of accessible forms of the proposed rule or comments may contact the Chief Information Officer at (505)476-0400.

DONE, this _____ day of _____, 2005.

INFORMATION TECHNOLOGY COMMISSION

_____
By: Carroll Cagle, Chair

NEW MEXICO MEDICAL BOARD

Notice

The New Mexico Medical Board will convene a regular Board Meeting on Thursday, August 18, 2005 at 8:00 a.m. that may continue on Friday, August 19, 2005 at 8:00 a.m. in the Conference Room, 2055 S. Pacheco, Building 400, Santa Fe, New Mexico. A Public Rule Hearing will be held on Thursday, August 18, 2005 at 1:30 p.m. The meeting will reconvene after the Hearing to take action on the proposed rules. In addition to the open meeting the Board may go into Executive Session pursuant to the Open Meetings Act §10-15-1(H) to discuss licensing or limited personnel issues.

The purpose of the Rule Hearing is to consider amending 16.10.2 NMAC (Physicians: Licensure Requirement), 16.10.3 NMAC (Examinations), 16.10.13 NMAC (Use of Devices & Procedures by Unlicensed Personnel), 16.10.15 NMAC (Physician Assistants: Licensure & Practice Requirements) and to add 16.10.17 NMAC (Management of Medical Records). These amendments will make licensing requirements consistent with changes in the law, amend the requirements for completion of examinations, provide further requirements for procedures performed by medical assistants under the supervision of a physician, modify practice requirements for physician assistants, and establish requirements for the management of medical records.

A final agenda for the board meeting will be available at the board office on August 17, 2005. 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., August 12, 2005, to the board office, 2055 S. Pacheco, Building 400, Santa Fe, NM, 87505. Copies of the proposed rules are available on request from the Board office at the address listed above, by phone (505) 476-7220, or on the Internet at www.nmmb@state.nm.us.

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 or meeting, please contact Lynnelle Tipton, Administrative Assistant at 2055 S.

Pacheco, Building 400, Santa Fe, NM at least one week prior to the meeting. Public documents, including the agenda and minutes, can be provided in various accessible formats. Please contact the Executive Director if a summary or other type of accessible format is needed.

NEW MEXICO DEPARTMENT OF PUBLIC SAFETY

NEW MEXICO DEPARTMENT OF PUBLIC SAFETY
NOTICE OF PUBLIC HEARING

The New Mexico Department of Public Safety (NMDPS) will be holding a Public Hearing for the sake of receiving comments on proposed amendments to Title 10, Chapter 10, Part 2 of NMAC, the application procedures governing the Edward Byrne Memorial Justice Assistance Grant Program. The hearing will be held at 1:30 P.M. on Friday, July 8, 2005 at the New Mexico Law Enforcement Academy Auditorium, 4491 Cerrillos Road, Santa Fe, New Mexico 87507. Proposed amendments to the Rule include, but are not limited to, changes, additions, deletions, and clarifications of the application process.

Copies of the proposed amendments shall be made available to the public ten days prior to the Public Hearing and may be obtained by calling 505-827-9062. Comments on these amendments are invited. Oral comments may be made at the hearing, or written comments may be submitted by mail to the Grants Accountability and Compliance Section, New Mexico Department of Public Safety, Post Office Box 1628, Santa Fe, New Mexico 87504-1628, no later than July 13, 2005. Any individual with a disability, who is in need of a reader, amplifier, or other form of auxiliary aid or service in order to attend or participate in the hearing, should contact Annette Jacques, 505-827-9062 at least ten (10) days prior to the hearing.

NEW MEXICO PUBLIC SCHOOL CAPITAL OUTLAY COUNCIL

PUBLIC SCHOOL FACILITIES AUTHORITY

PUBLIC SCHOOL CAPITAL OUTLAY COUNCIL
Public School Facilities Authority
2019 Galisteo, Suite B-1
Santa Fe, New Mexico 87501-2786

NOTICE OF PROPOSED RULEMAKING

The Public School Capital Outlay Council ("Council") is authorized to promulgate rules pursuant to Section 22-24-5 New Mexico Statutes Annotated 1978. The Council will consider the following:

Rule Number	Proposed Action	Rule Name
6.27.1 NMAC	Amend rule	PUBLIC SCHOOL CAPITAL OUTLAY COUNCIL: GENERAL PROVISIONS
6.27.2 NMAC	Amend rule	PUBLIC SCHOOL CAPITAL OUTLAY COUNCIL: PUBLIC SCHOOL FACILITIES AUTHORITY
6.27.3 NMAC	Amend rule	PUBLIC SCHOOL C APITAL OUTLAY COUNCIL: APPLICATION AND GRANT ASSISTANCE PROCEDURES AND REQUIREMENTS RELATING TO PREVENTIVE MAINTENANCE PLANS (*PROPOSED RULE NAME CHANGE)*
6.27.30 NMAC	Amend rule	PUBLIC SCHOOL CAPITAL OUTLAY COUNCIL: STATEWIDE ADEQUACY STANDARDS

A public hearing is scheduled on August 1, 2005 from 9:00 a.m. to 11:00 a.m. in Room 317 of the State Capitol, Santa Fe, New Mexico. The text of the proposed rules may be viewed on the Public Schools Facilities Authority's website (www.nmschoolbuildings.org) or may be obtained from Lena Archuleta, Administrative Assistant, at (505) 988-5989 or larchuleta@psfa.k12.nm.us. Interested individuals may testify at the public hearing or submit written comments regarding the proposed amendments. Written comments should be submitted to Tim Berry, Deputy Director, Public School Facilities Authority, at the address shown above or tberry@psfa.k12.nm.us, or telefaxed to (505) 988-5933. Written comments must be received no later than 5:00 pm on August 1, 2005; however, the submission of written comments as soon as possible is encouraged.

The Council will act on the proposed rules at a public meeting for which notice is given in accordance with the Council's Open Meetings Policy. The agenda will be available at least twenty-four hours prior to the meeting from Ms. Archuleta.

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. Archuleta as soon as possible. The Council requests at least ten (10) days advance notice to provide requested special accommodations.

End of Notices and Proposed Rules Section

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Adopted Rules

NEW MEXICO DNA IDENTIFICATION OVERSIGHT COMMITTEE AND ADMINISTRATIVE CENTER

This is an amendment to 10.14.200 NMAC, Sections 3, 6, 7, 8, 9, 10, and 11. The purpose of these changes are to effect the amending of Sections 10.14.200.3, 10.14.200.6, Subsections F, H and W of 10.14.200.7, Subsection A of Section 10.14.200.8, Subsections G, H and K of Section 10.14.200.9, Subsections B and E of Section 10.14.200.10, Paragraph 3 of Subsection C, Paragraph 3 of Subsection D and Paragraph 4 of Subsection E of Section 10.14.200.11 all to be effective on 7/1/2005.

10.14.200.3 STATUTORY AUTHORITY: Section 29-11A-5.G NMSA 1978, 29-16-4.B.6 NMSA 1978, 29-16-5.B NMSA 1978 and 29-16-5.E NMSA 1978.
[3/1/1998; 10.14.200.3 NMAC - Rn, 10 NMAC 14.200.3, 5/1/2000; A, 7/1/2003; A, 7/1/2005]

10.14.200.6 OBJECTIVE: To establish a DNA identification system for covered offenders, unidentified persons and unidentified human remains. To facilitate the use of DNA records by local, state and federal law enforcement agencies [~~and the state medical investigator~~] in the identification, detection or exclusion of persons in connection with criminal investigations [~~or~~], the registration of sex offenders required to register pursuant to the provisions of the Sex Offender Registration and Notification Act and to facilitate the use of DNA records by local, state and federal law enforcement agencies and the state medical investigator in the identification of unidentified persons or unidentified human remains pursuant to the DNA Identification Act.
[3/1/1998; 10.14.200.6 NMAC - Rn, 10 NMAC 14.200.6, 5/1/2000; A, 7/1/2003; A, 7/1/2005]

10.14.200.7 DEFINITIONS:

A. "Administrative center" means the law enforcement agency that administers and operates the DNA identification system and is governed by the DNA oversight committee.

B. "Analysis" means DNA profile generation.

C. "Buccal cell" means cells from the interior linings of the cheek and gum.

D. "CODIS" means the federal bureau of investigation's national DNA index system for storage and exchange of DNA records submitted by designated forensic DNA laboratories.

E. "Collection kit" see Subsection M of 10.14.200.7 NMAC.

F. "Core loci" means the chromosomal locations designated as [~~appropriate for database use in CODIS~~] being required for a convicted offender profile to be considered complete by the board of the national DNA index system, and consistent with the federal DNA Identification Act of 1994 and subsequent federal laws.

G. "Covered offender" for purposes of assessment means any person convicted of a felony offense, committed after July 1, 1997, and as defined by Section 29-16-3.D NMSA 1978 and Section 29-16-6 NMSA 1978.

H. "Covered offender" for purposes of DNA sample collection means any person [~~convicted of a felony offense~~] as defined by Section 29-16-3.D NMSA 1978 and Section 29-16-6.A NMSA 1978.

I. "DNA" means deoxyribonucleic acid.

J. "DNA Identification Act" means Sections 29-16-1 to 29-16-13 NMSA 1978, and any subsequent amendments or additions to these sections, the law that authorizes the DNA identification system and the DNA oversight committee.

K. "DNA identification system" means the system established pursuant to the DNA Identification Act.

L. "DNA oversight committee" means the DNA identification system oversight committee.

M. "DNA sample collection kit" means materials designed for the collection of DNA samples.

N. "FTA card" means an FTA collection card, a card of blotter paper designed for the collection of liquid biological samples.

O. "Head of the administrative center" means the person who supervises the day-to-day operations of the administrative center.

P. "Identification system" see Subsection K of 10.14.200.7 NMAC.

Q. "In writing" means a document hand or typewritten on paper and includes the use of facsimile copies or computer requests that can be printed.

R. "Kit" see Subsection M of 10.14.200.7 NMAC.

S. "Records" means the results of analysis, testing, and related information.

T. "Sample" means a sample of biological material sufficient for DNA testing.

U. "Sample collection kit" see Subsection M of 10.14.200.7 NMAC.

V. "Sample kit" see Subsection M of 10.14.200.7 NMAC.

W. "Sample profile hit" means a match [~~on all~~] of the examined loci as determined by the servicing forensic DNA laboratory.

X. "Secured" means limited and controlled access only by authorized personnel including use of protection and safety devices to safeguard any and all functions of that equipment or facility.

Y. "Secured computer" means a computer that is a stand-alone computer without remote access that is password protected, with all access audited and archived, or; a computer that is connected to a dedicated, encrypted data communications line that is password protected, with all access audited and archived.

Z. "System" see Subsection K of 10.14.200.7 NMAC.
[3/1/1998; 10.14.200.7 NMAC - Rn & A, 10 NMAC 14.200.7, 5/1/2000; A, 7/1/2003; A, 7/1/2005]

10.14.200.8 COLLECTION AND TRANSFER OF OFFENDER SAMPLES AND FEES:

A. Collection of samples from covered offenders shall be performed by employees of the department of corrections adult prisons [~~,~~] or probation and parole divisions, by employees of the county sheriff office, members of the administrative center or persons designated by the administrative center as trained by and in coordination with the administrative center, utilizing the collection protocol approved by the oversight committee.

B. Collection and deposit of assessed fees from covered offenders shall be performed by employees of the department of corrections adult prisons and probation and parole divisions pursuant to policies and procedures established by the department of corrections.

C. The department of corrections shall be responsible for establishing policies and procedures for the collection of samples and assessed fees from covered offenders utilizing a collection protocol to be approved by the DNA oversight committee when custody is maintained by private or out-of-state, probation and parole or corrections facilities.

D. DNA sample collection kits and information on the collection, storage, and transfer of samples shall be provided at no cost by the administrative center.

E. The routine method of sample collection shall be by buccal cell

swabbing and transfer to a FTA collection card using the standardized sample collection kit as supplied by the administrative center. In non-routine circumstances, including a refusal by a covered offender, the collection shall be referred to the administrative center, require a written consent or court order, and shall be collected and coordinated by trained persons designated by the administrative center pursuant to Sections 29-16-3.K and 29-16-9 NMSA 1978.

F. Questions on supplies, collection, packaging, should be directed to the administrative center.

[3/1/1998, A, 4/30/99; 10.14.200.8 NMAC - Rn, 10 NMAC 14.200.8, 5/1/2000; A, 7/1/2003; A, 7/1/2005]

10.14.200.9 HANDLING AND SECURITY OF SAMPLES:

A. DNA records and samples are confidential and shall not be disclosed except as authorized by the DNA oversight committee and as governed by the DNA Identification Act.

B. All files, computer, and sample storage systems maintained by the administrative center pursuant to the DNA Identification Act shall be secured. Computers which contain personal identifying information shall be of the stand-alone variety as defined in Subsection Y of 10.14.200.7 NMAC. Access shall be limited to employees of the administrative center as authorized by the head of the administrative center pursuant to and directed by the official functions and duties stated in Section 29-16-4.B.1 NMSA 1978, and to technical repair personnel as required to maintain the system as authorized by the head of the administrative center.

C. Both state and national database searches shall be performed via secured computer systems.

D. Any person who willfully discloses, seeks to obtain or use information from the DNA identification system for purposes not authorized in these rules and in violation of Section 29-16-12 NMSA 1978 shall be subject to the penalties thereof.

E. All samples received by the administrative center for DNA analysis shall be considered potentially bio-hazardous. Universal safety precaution procedures shall be followed when handling biological samples.

F. These samples shall be handled, examined, and processed one at a time to avoid possible cross-contamination from another biological sample or from the examiner.

G. All sample kits shall be received in a sealed condition. If the kit is not sealed upon receipt, it shall be [~~noted on the sample checklist/flow sheet~~] documented and the head of the administrative center shall be notified. The sample shall be rejected and a request for a new sample shall be made by the head of the administrative center.

H. If the documentation or certification sections are not filled out, it shall be [~~noted on the sample checklist/flow sheet~~] documented and the head of the administrative center shall be notified. The decision as to whether to accept the sample or request a new sample shall be made by the head of the administrative center. The decision and the justification for that decision shall be [~~noted on the sample checklist/flow sheet~~] documented.

I. The FTA card envelope shall be opened to examine the FTA collection card. The person's name on the card shall be verified with the person's name on the subject information section of the sample collection kit. If the names do not match, the head of the administrative center shall be notified and shall reject the sample unless the identification of the donor can be verified through fingerprint comparison.

J. Each sample shall receive a unique identifying database number that does not include any personal identification information. The database number shall be placed on the front of the sample collection kit and on the FTA card.

K. The FTA card shall be returned to the FTA card envelope affixed to the inside of the kit and placed into secured storage until processed for analysis. [~~The sample checklist/flow sheet is then securely filed in the Administrative Center via hard-copy or electronic means.~~]

[3/1/1998; 10.14.200.9 NMAC - Rn & A, 10 NMAC 14.200.9, 5/1/2000; A, 7/1/2003; A, 7/1/2005]

10.14.200.10 SAMPLE PROCESSING AND ANALYSIS:

A. All samples received by the administrative center for DNA analysis should be considered potentially bio-hazardous. Universal safety precaution procedures shall be followed when handling biological samples.

B. The mechanism of sample collection authorization for samples collected pursuant to Section 29-16-6.B NMSA 1978 shall be documented and a copy [~~of~~] of that authorization maintained by the administrative center.

C. These samples shall be handled, examined, and processed individually to avoid possible cross-contamination from another biological sample or from the examiner.

D. Samples tested shall follow DNA testing procedures approved by the administrative center. Remaining samples shall be returned to secured storage.

E. The genetic markers analyzed shall consist of those contained in commercial analysis kits approved by the DNA oversight committee and [~~as core loci by CODIS~~] approved by the board of the national DNA index system, having been selected for identification and statistical purposes only.

F. Excess extracted or amplified offender DNA shall be destroyed within thirty (30) days after completion of analysis.

G. Excess DNA collected or extracted pursuant to Section 29.16.2.C NMSA 1978 shall be retained by the administrative center, the analyzing laboratory or the submitting agency at the discretion of the submitting agency. Excess amplified DNA generated pursuant to Section 29.16.2.C NMSA 1978 shall be destroyed within thirty (30) days after completion of analysis.

H. No written reports shall be released on any specific DNA sample except as authorized by the DNA Identification Act and these rules.

[3/1/1998; 10.14.200.10 NMAC - Rn & A, 10 NMAC 14.200.10, 5/1/2000; A, 7/1/2003; A, 7/1/2005]

10.14.200.11 ACCESS TO DNA SAMPLE INFORMATION, RECORDS AND SAMPLES:

A. Access to or disclosure of DNA records and samples collected shall be authorized only in the following circumstances:

(1) when used as statistical or research information, and only when all personal identification is removed; or,

(2) for identification, comparison, and investigative purposes, to local, state, and federal law enforcement agencies and the state medical investigator in response to official inquiries as authorized by Sections 29-16-2 NMSA 1978, 29-16-8.B NMSA 1978 and these rules; or,

(3) pursuant to court order.

B. Access to the DNA identification system by authorized law enforcement agencies and the state medical investigator shall be through their servicing forensic DNA laboratory or by direct request to the head of the administrative center.

C. DNA records and samples:

(1) All requests for information on DNA records or requests for DNA samples shall be submitted in writing to the administrative center.

(2) The head of the administrative center shall verify the validity of all requests prior to releasing any information or DNA samples pursuant to the DNA Identification Act.

(3) A copy of the request and resulting action shall be placed [~~in~~] with the

original [~~case file~~] sample records.

(4) A separate file shall be established where copies of all requests and resulting actions shall be kept.

D. DNA database searches:

(1) All requests for searches of or through the administrative center DNA database computers shall be submitted in writing to the administrative center.

(2) The head of the administrative center shall verify the validity of all requests pursuant to the DNA Identification Act, prior to initiating any database searches or releasing information from such searches and shall reject inappropriate or invalid requests. Such decisions may be appealed to the DNA oversight committee.

(3) A copy of the request and resulting action shall be placed [~~in~~] with the original [~~case folder~~] sample records.

(4) A separate file shall be established where copies of all requests and resulting action shall be kept.

E. Database hits:

(1) If a sample profile hit should occur, a reanalysis of the stored DNA sample shall be performed, if possible, to verify the generated profile.

(2) A written report indicating the match shall be forwarded to the requesting agency through their servicing laboratory or directly by the head of the administrative center. Release of personal identifying information shall be made only after compliance with Subsection C of 10.14.200.11 NMAC.

(3) Should a profile not be confirmed or if a hit does not occur, a written report to that effect shall be forwarded to the requesting agency through their servicing laboratory or directly by the head of the administrative center.

(4) All written reports that possess an original signature shall be kept by the administrative center. Copies of reports that possess an original signature will be distributed as deemed appropriate by the head of the administrative center. As required, a certified copy of a report that possesses an original signature will be distributed as deemed appropriate by the head of the administrative center.

F. Only DNA records that directly relate to the identification characteristics of individuals shall be collected and stored in the state DNA database. The information contained in the DNA identification system database shall not be collected, stored, or released for the purpose of obtaining information about physical characteristics, traits, or predisposition for a disease or mental illness or behavior and shall not serve any purpose other than those allowed by the DNA Identification Act.

G. CODIS

(1) Upon the initiation of CODIS, the administrative center will contribute data obtained from the DNA identification system.

(2) The information maintained and accessed by CODIS shall adhere to the rules and regulations established by the FBI for CODIS access.

(3) Both state and national searches shall be performed via secured computer systems.

[3/1/1998; 10.14.200.11 NMAC - Rn & A, 10 NMAC 14.200.11, 5/1/2000; A, 1/23/2002; A, 7/1/2003; A, 7/1/2005]

NEW MEXICO DEPARTMENT OF FINANCE AND ADMINISTRATION

LOCAL GOVERNMENT DIVISION

TITLE 18 TRANSPORTATION AND HIGHWAYS
CHAPTER 20 TRAFFIC SAFETY
PART 12 IGNITION INTERLOCK DEVICES FEES AND PAYMENTS

18.20.12.1 ISSUING AGENCY: Department of Finance and Administration.
[18.20.12.1 NMAC - N/E, 6-17-05]

18.20.12.2 SCOPE: This rule applies to the fee amount imposed upon a person pursuant to Section 66-8-102.3 NMSA 1978 and to all vendors required to collect and submit fees collected pursuant to Section 66-8-102.3 NMSA 1978.
[18.20.12.2 NMAC - N/E, 6-17-05]

18.20.12.3 STATUTORY AUTHORITY: Section 66-8-102.3 NMSA 1978.
[18.20.12.3 NMAC - N/E, 6-17-05]

18.20.12.4 DURATION: Emergency, in effect until June 30, 2006.
[18.20.12.4 NMAC - N/E, 6-17-05]

18.20.12.5 EFFECTIVE DATE: June 17, 2005, unless a later date is cited at the end of a section.
[18.20.12.5 NMAC - N/E, 6-17-05]

18.20.12.6 OBJECTIVE: The purpose of this rule is to determine the fee amount mandated by Section 66-8-102.3 NMSA 1978 as amended effective June 17, 2005.
[18.20.12.6 NMAC - N/E, 6-17-05]

18.20.12.7 DEFINITIONS:

A. Division means the local government division of the New Mexico department of finance and Administration.

B. Bureau means the traffic safety bureau of the New Mexico department of transportation.

C. Vendor means licensee or service center operator as defined by subsection Z of 18.20.11.7 NMAC licensed by the bureau to provide ignition interlock devices and related services in the state of New Mexico.
[18.20.12.7 NMAC - N/E, 6-17-05]

18.20.12.8 IGNITION INTERLOCK DEVICE FEE PAYMENT: The vendor shall submit to the division within 30 days of the first installation or service of an ignition interlock device all of the fee set forth in 18.20.12.10 NMAC required to be collected by the vendor.
[18.20.12.8 NMAC - N/E, 6-17-05]

18.20.12.9 IGNITION INTERLOCK FORMS: The ignition interlock device fees and requests for reimbursement shall be submitted on forms provided and approved by the division and must be signed by the vendor who possesses a license from the bureau in accordance with the requirements of 18.20.11 NMAC. If a vendor fails to use the approved forms, all indigent payments to the vendor shall cease until proper forms are received. If a vendor continues to submit improper forms, the division shall recommend to the bureau that the vendor's license be suspended or revoked.
[18.20.12.9 NMAC - N/E, 6-17-05]

18.20.12.10 IGNITION INTERLOCK DEVICE FEE AMOUNT: Pursuant to Section 66-8-102.3 A. NMSA 1978, the ignition interlock device fee shall be one hundred dollars ($100.00) for each year the person is required to operate only vehicles equipped with an ignition interlock device.
[18.20.12.10 NMAC - N/E, 6-17-05]

18.20.12.11 LATE PAYMENT OF FEE: Late payment of the ignition interlock device fee set forth in 18.20.12.10 NMAC by any vendor to the division shall be determined by the division. If the division determines that a payment from the vendor is late, all indigent payments to the vendor shall cease until payment is received. If a vendor continues to pay the fee set forth in 18.20.12.10 NMAC late, the division shall recommend to the bureau that the vendor's license be suspended or revoked.
[18.20.12.11 NMAC - N/E, 6-17-05]

18.20.12.12 CHANGE OF ADDRESS: Vendors subject to Section 66-8-102.3 NMSA 1978 shall inform the division of any change of address within fifteen days of the change. Any notice mailed by

the division by United States postal service to such vendor is presumed to be effective and binding upon that vendor when it is mailed to the last address shown in the division's records.

[18.20.12.12 NMAC - N/E, 6-17-05]

HISTORY OF 18.20.12 NMAC: [RESERVED].

NEW MEXICO DEPARTMENT OF GAME AND FISH

This is an amendment to 19.31.3 NMAC section 11. Effective date is 6-30-2005.

19.31.3.11 RESTRICTIONS:

A. One license per big game species per year: It shall be unlawful for anyone to hold more than one permit or license for any one big game species during the current license year unless otherwise allowed by rule.

B. Valid dates of license or permit: All permits or licenses shall be valid only for the specified dates, legal sporting arms, bag limit and area. Except that a permit or license will be valid on the contiguous deeded land of private property that extends into an adjacent GMU or AMU, that is open to hunting for that species, when the license holder is in possession of current, valid written permission from the appropriate landowner. This exception shall only apply when the adjacent unit has the same restrictions as to weapon type, bag limit, season dates and license availability.

C. Rocky Mountain bighorn sheep - once-in-a-lifetime hunts: It shall be unlawful for anyone to apply for a Rocky Mountain bighorn sheep license if one has previously held a license to hunt Rocky Mountain bighorn sheep in New Mexico, including the youth-only bighorn hunt. However, a person that has received the youth-only license is allowed to apply for the regular once-in-a lifetime bighorn hunts as long as they are eligible. Exception: An applicant is eligible to submit a bid for the special bighorn auction and raffle licenses whether or not he/she has previously held a license to hunt Rocky Mountain or desert bighorn sheep in New Mexico.

D. Desert bighorn sheep-once-in-a-lifetime: It shall be unlawful for anyone to apply for a desert mountain bighorn sheep license if one has previously held a license to hunt desert mountain bighorn sheep in New Mexico. Exception: An applicant is eligible to submit a bid for the special bighorn auction and raffle licenses whether or not he/she has previously held a license to hunt Rocky Mountain or desert bighorn sheep in New Mexico.

E. [RESERVED]

F. Ibex - once-in-a-lifetime: It shall be unlawful for anyone to apply for a once in a lifetime ibex license if he/she ever held a once in a lifetime license to hunt ibex. Youth ibex hunts, year-round off -mountain hunts, and hunts for female or immature (FIM) ibex, as designated in 19.31.8 NMAC, are not once-in-a-lifetime hunts.

G. Oryx - once-in-a lifetime: It shall be unlawful, beginning April 1, 1993, for anyone to apply for an oryx license if he/she ever held a "once-in-a-lifetime" license to hunt oryx. Exception: Depredation population reduction oryx hunts, youth oryx hunts and incentive hunts are not once-in-a-lifetime hunts.

H. Valle Vidal (as described in Subsection A of 19.30.4.11 NMAC):

(1) It shall be unlawful for anyone to apply for a license to hunt bull elk on the Valle Vidal if he/she has ever held a license allowing them to take a bull elk on the Valle Vidal since 1983. This restriction applies to all licenses valid for a bag limit of mature bull (MB) , either sex (ES) or mature bull/antlerless (MB/A). It shall be unlawful for anyone to apply for a license to hunt antlerless elk on the Valle Vidal if he/she has ever held a Valle Vidal elk license valid for a bag limit of antlerless since 1983. Either sex (ES) or mature bull/antlerless (MB/A) shall not be considered as an "antlerless" license for this restriction. Persons who have held a Valle Vidal elk license through any incentive program are exempt from this restriction.

(2) It shall be unlawful to hunt bear on the Valle Vidal except for properly licensed bear hunters that possess a Valle Vidal elk hunting muzzleloader, bow, or rifle license and only during the dates of the elk hunt specified. Use of dogs shall not be allowed for bear hunting on the Valle Vidal.

I. Transfer of permits or licenses: It shall be unlawful to transfer permits or licenses to other persons, areas, or other hunt periods except as permitted by regulation adopted by the state game commission.

J. Refunds will not be made for any license or permit after it has been awarded or issued except as permitted by regulation adopted by the state game commission.

K. More than one application: It shall be unlawful to submit more than one application per species for any license issued through a special drawing, unless otherwise permitted by regulation. Exception: An individual may apply for both a population reduction hunt on public or private land and a special drawing hunt. However, an applicant shall follow the application procedures outlined in 19.31.3.8 NMAC.

L. Deer hunts: It shall be unlawful for any person who is issued a deer hunting permit:

(1) to hunt with any sporting arms type other than that for which his/her deer permit is validated;

(2) to hunt during any season other than that for which his/her deer permit is validated;

(3) to hunt in any GMU other than that for which his/her deer permit is validated;

(4) to hunt deer on public land in any GMU with a private land deer permit**, except in conjunction with this subsection, if it is on state land where there is a valid agreement for unitizing state leased and privately owned or leased lands**; or

(5) to hunt private property without possessing a valid deer permit, the proper deer license and written permission.

M. Handicapped fishing or handicapped general hunting license qualifications: To hold a handicapped fishing or handicapped general hunting license, the individual must be a resident of New Mexico and must show proof of a severe disability by reason of one or more physical disabilities resulting from amputation, arthritis, blindness, burn injury, cancer, cerebral palsy, cystic fibrosis, muscular dystrophy, musculoskeletal disorders, neurological disorders, paraplegia, quadriplegia and other spinal cord conditions, sickle cell anemia, and end-stage renal disease, or who has a combination of permanent disabilities which cause comparable substantial functional limitation. Reasonable accommodation will be made, relating to these licenses, upon request.

N. Handicapped elk or antelope license qualifications: To hold a handicapped elk or antelope license, any individual must show proof of a permanent mobility restriction which limits their activity to a walker, wheelchair, or two crutches, or severely restricts the movement in both arms or who has a combination of permanent disabilities which cause comparable substantial functional limitation.

O. One deer permit per year: It shall be unlawful for anyone to hold more than one deer permit during the current license year.

P. Youth hunts: Only applicants who have not reached their 18th birthday by the opening day of the hunt are eligible to apply for or participate in a youth only hunt. Applicant for firearm hunts must provide hunter education certificate number on application.

Q. Bear entry hunt: It shall be unlawful to hunt bear in designated

wildlife areas without having a valid bear entry permit and a valid license in the hunter's possession. Bear entry hunters shall be allowed to hunt any other bear hunt provided they have a valid license and tag.

R. An individual making license application shall supply the department on the appropriate form with all required personal information including, but not limited to name, address, date-of-birth, last four digits of his/her social security number prior to an application form being processed or a license being awarded.

S. It shall be unlawful to hunt pheasant in Valencia county without possessing a valid pheasant permit, the proper license and written permission.

(1) Exception: A hunter with a Valencia county pheasant north hunt or south hunt area permit is not required to have written permission for these specific hunt areas.

(2) It is unlawful for a hunter that successfully draws a Valencia county pheasant north hunt or south hunt to hunt any other area or property outside of the designated hunt area in Valencia county that same season.

T. GMU 4 and 5A private land only hunts: Deer hunt applicants in GMUs 4 and 5A must obtain a special application from landowner. GMU 4 and 5A landowners may be required to provide proof of land ownership to obtain special application forms.

U. Military only hunts: Applicants must be full time active military and proof of military status must accompany application.

[19.31.3.11 NMAC - Rp, 19.31.3.11 NMAC, 12-30-04, A; 6-30-05]

NEW MEXICO DEPARTMENT OF GAME AND FISH

Explanatory paragraph: This is an amendment to 19.31.8 NMAC, Sections 13 and 24, effective 6-30-2005. The amendment adds Game Management Unit 36 to the available units for hunting antlerless elk during the month of January and adds the Southeast Area Chief as an approver with respect to GMU 36 with concurrence of the Chairman of the State Game Commission.

19.31.8.13 ELK (2005-2006):

F. Private land elk hunts for ranches designated as "RANCH ONLY" shall be limited to the following season dates and legal sporting arms. All private land mobility impaired and youth only hunters must satisfy licensing requirements as stated in 19.31.3 NMAC, in order to hunt during the "Mobility Impaired Hunters" or "Youth Only" hunt periods.

Legal sporting arms	Open GMUs or area	Hunt date
bows only	13, 15, 16A, 16B, 16C, 16D, 16E, 17, 21A, 21B, 22, 23, 24, 52	09/01/2005 - 09/15/2005
bows only	13, 15, 16A, 16B, 16C, 16D, 16E, 17, 21A, 21B, 22, 23, 24	09/16/2005 - 09/24/2005
bows only	6A, 6C	09/01/2005 - 09/15/2005
bows only	6A, 6C, 52	09/16/2005 - 09/22/2005
bows only	2, 4, 5A, 5B, 7, 9, 10, 12, 18, 34, 36, 37, 42, 44/45, 46, 47, 48, 49, 50, 51, 53, 54 (except northeast portion), 55A, 56A, 57, 58	09/01/2005 - 09/22/2005
muzzle loading rifl es and bows	6C, 9, 10, 34, 36, 37, 44/45, 48, 52, 53	any 5 consecutive days, Oct. 1 - Dec. 31, 2005
muzzle loading rifles and bows	2, 6A, 7	any 5 consecutive days, Oct. 8 - Dec. 31, 2005
muzzle loading rifles and bows	13, 15, 16E, 17, 22, 23, 24	any 5 consecutive days, Oct. 15 - Dec 31, 2005
youth only - muzzle loading rifles and bows	15	10/08/2005 – 10/12/2005
any legal sporting arms	4, 5A, 12, 41, 42, 43, 46, 47, 49, 54 (except northeast portion), 55A, 56A, 56 (sierra grande portion), 57, 58	any 5 consecutive days, Oct 1 - Dec. 31, 2005
any legal sporting arms	5B, 10, 34, 36, 37, 44/45, 50, 51, 52, 53.	any 5 consecutive days, Oct. 8 - Dec. 31, 2005
any legal sporting arms	2, 6A, 6C, 7, 16A, 16B, 16C, 16D, 21A, 21B, 48	any 5 consecutive days, Oct. 15 - Dec. 31, 2005
any legal sporting arms	16E, 22, 23, 24	any 5 consecutive days, Oct. 22 - Dec. 31, 2005
any legal sporting arms	9	any 5 consecutive days, Nov. 5 - Dec. 31, 2005
rifles only (except GMU 13 is muzzle loading rifles only)	13, **36,** 46, 54(except northeast portion), 55A, 56, 57, 58 with approval of NE **, SE** or SW area chiefs and the state game commission chairman. ANTLERLESS ELK ONLY	any 5 consecutive days between Jan. 1 - 31, 2006

youth only - any legal sporting arms	34	09/24/2005 - 09/28/2005
youth only - any legal sporting arms	16A, 16D, 24	10/08/2005 - 10/12/2005
mobility impaired only	16A, 16D	10/08/2005 - 10/12/2005
mobility impaired only	34	09/24/2005 - 09/28/2005
mobility impaired only	51	10/01/2005 - 10/05/2005
mobility impaired only	9 (including Water canyon but not Marquez WMAs)	11/05/2005 - 11/09/2005

[19.31.8.13 NMAC - Rp, 19.31.8.13 NMAC, 4-1-2005, A; 6-30-2005]

19.31.8.24 ELK (2006-2007):

F. Private land elk hunts for ranches designated as "RANCH ONLY" shall be limited to the following season dates and sporting arms types. All private land mobility impaired and youth only hunters must satisfy licensing requirements as stated in 19.31.3 NMAC, in order to hunt during the "Mobility Impaired Hunters" or "Youth Only" hunt periods.

Legal sporting arms	Open GMUs or area	Hunt date
bows only	13, 15, 16A, 16B, 16C, 16D, 16E, 17, 21A, 21B, 22, 23, 24, 52	09/01/2006 - 09/15/2006
bows only	13, 15, 16A, 16B, 16C, 16D, 16E, 17, 21A, 21B, 22, 23, 24	09/16/2006 - 09/24/2006
bows only	6A, 6C	09/01/2006 - 09/15/2006
bows only	6A, 6C, 52	09/16/2006 - 09/22/2006
bows only	2, 4, 5A, 5B, 7, 9, 10, 12, 18, 34, 36, 37, 42, 44/45, 46, 47, 48, 49, 50, 51, 53, 54 (except northeast portion), 55A, 56A, 57, 58	09/01/2006 - 09/22/2006
muzzle loading rifles and bows	6C, 9, 10, 34, 36, 37, 44/45, 48, 52, 53	any 5 consecutive days, Sept 30 - Dec. 31, 2006
muzzle loading rifles and bows	2, 6A, 7	any 5 consecutive days, Oct. 7 - Dec 31, 2006
muzzle loading rifles and bows	13, 15, 16E, 17, 22, 23, 24	any 5 consecutive days, Oct. 14 - Dec. 31, 2006
youth only - muzzle loading rifles and bows	15	10/07/2006 – 10/11/2006
any legal sporting arms	4, 5A, 12, 41, 42, 43, 46, 47, 49, 54 (except northeast portion), 55A, 56A, 56 (sierra grande portion, 57, 58	any 5 consecutive days, Sept 30 - Dec. 31, 2006
any legal sporting arms	5B, 10, 34, 36, 37, 44/45, 50, 51, 52, 53	any 5 consecutive days, Oct. 7 - Dec. 31, 2006
any legal sporting arms	2, 6A, 6C, 7, 16A, 16B, 16C, 16D, 21A, 21B, 48	any 5 consecutive days, Oct. 14 - Dec. 31, 2006
any legal sporting arms	16E, 22, 23, 24	any 5 consecutive days, Oct. 21 - Dec. 31, 2006
any legal sporting arms	9	any 5 consecutive days, Nov. 4 - Dec. 31, 2006
rifles only (except GMU13 is muzzle loading rifles only)	13, **36,** 46, 54 (except northeast portion), 55 A, 56, 57, 58 with approval of NE **, SE** or SW area chiefs and the state game commission chairman. ANTLER -LESS ELK ONLY	any 5 consecutive days between Jan. 1 - 31, 2007
youth only - any legal sporting arms	34	09/23/2006 - 09/27/2006
youth only - any legal sporting arms	16A, 16D	10/07/2006 - 10/11/2006
mobility impaired only	16A, 16D	10/07/2006 - 10/11/2006
mobility impaired only	34	09/23/2006 - 09/27/2006
mobility impaired only	51	09/30/2006 - 10/04/2006

mobility impaired only	9 (including Water canyon but not Marquez WMAs)	11/04/2006 - 11/08/2006

[19.31.8.24 NMAC - Rp, 19.31.8.24 NMAC, 4-1-2005, A; 6-30-2005]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 262 MEDICAID ELIGIBILITY - STATE COVERAGE INSURANCE (SCI) (CATEGORY 062)
PART 400 RECIPIENT POLICIES

8.262.400.1 ISSUING AGENCY: New Mexico Human Services Department.
[8.262.400.1 NMAC - N, 7-1-05]

8.262.400.2 SCOPE: The rule applies to the general public.
[8.262.400.2 NMAC - N, 7-1-05]

8.262.400.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2 authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act, subject to special terms and conditions.
[8.262.400.3 NMAC - N, 7-1-05]

8.262.400.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver, and subject to availability of funds.
[8.262.400.4 NMAC - N, 7-1-05]

8.262.400.5 EFFECTIVE DATE: July 1, 2005, unless a later date is cited at the end of a section.
[8.262.400.5 NMAC - N, 7-1-05]

8.262.400.6 OBJECTIVE: The objective of the SCI program is to reduce the number of uninsured New Mexico residents by implementation of a basic coverage health insurance benefit provided by contracted managed care organizations (MCO), with cost-sharing by beneficiaries, employers, and the state and federal governments.
[8.262.400.6 NMAC - N, 7-1-05]

8.262.400.7 DEFINITIONS:

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

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

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

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

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

F. **Category:** A designation of the automated eligibility system. SCI has one designated category-062 and three subcategories (062-A, 062-B, 062-C) that are assigned to an individual based on his or her income grouping. The assigned category is applicable for a period of 12 consecutive months regardless of changes in income or family status, subject to change by request from the recipient.

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

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

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

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

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

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

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

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

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

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

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

(1) father (biological or adopted);

(2) mother (biological or adopted);

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

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

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

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

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

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

(9) uncle of the whole or half

blood, uncle-in-law, great uncle, great-great uncle;

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

(11) first cousin and spouse of first cousin;

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

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

(14) nephew/niece and spouses.

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

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

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

T. **Health insurance:** Insurance against loss by sickness or bodily injury. The generic term for the forms of insurance that provide lump sum or periodic payments in the event of bodily injury, sickness, or disease, and medical expense.

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

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

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

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

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

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

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

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

CC. **Premium- employer-** A specific monthly payment payable to the MCO by employers who enroll their employees in SCI at a rate set by the department. This amount may be paid by an individual member not in an employer group in order to participate in SCI.

DD. **Premium- employee-** A specific monthly payment payable to the MCO calculated by the department based on a subcategory of eligibility representing an income grouping. 062A 0-100% FPL, 062B-101-150% FPL, 062C-151-200% FPL.

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

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

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

HH. **Voluntary drop:** The act of voluntarily terminating or discontinuing health insurance coverage. It will not be considered a voluntary drop when an individual (or spouse) fails to take advantage of an offer of health insurance by an employer (unless the insurance is SCI coverage), or fails or refuses to take advantage of a COBRA continuation policy. Also not considered to be a voluntary drop are loss of access to employer-sponsored insurance due to loss of employment, divorce, death of a spouse, or geographic move, loss of coverage as a dependent child, or loss of medicaid eligibility.

[8.262.400.7 NMAC - N, 7-1-05]

8.262.400.8 [RESERVED]

8.262.400.9 BASIS FOR DEFINING THE GROUP:

A. The request for assistance is the first step to determining which individuals are included in the assistance group.

B. Household composition:

(1) For a child to be considered part of the household, the child must be under the age of 19.

(2) To be considered a household of one, the individual, aged 19 or older, must be unmarried with no dependent children of his/her own.

(3) For other household definitions, refer to 8.202.400 NMAC.

[8.262.400.9 NMAC - N, 7-1-05]

8.262.400.10 WHO CAN BE COVERED UNDER SCI: To be covered under SCI, an individual must meet all eligibility and enrollment criteria for any given month. Eligibility may exist only via managed care enrollment with a contracted managed care organization. There is no fee-for-service eligibility or retroactive eligibility. The department may limit the number of covered individuals based on available funding.

[8.262.400.10 NMAC - N, 7-1-05]

8.262.400.11 ELIGIBILITY: To be eligible for SCI, an individual must be considered to have met all eligibility criteria regarding age, citizenship or alien status, noninsured status, voluntary drop of insurance, income, and living arrangement (i.e., living in a public institution). An eligibility determination will be made by the 45th day after the date of application. If it is determined that an individual does not meet all SCI eligibility criteria, a notice of denial with the reason for denial and rights to appeal will be issued. If it is determined that an individual meets all eligibility criteria, the individual will be awarded an "eligibility letter," which will notify the individual of their right to enroll, and of the fact that coverage will not begin unless and until the individual is enrolled with a SCI-contracted MCO.

[8.262.400.11 NMAC - N, 7-1-05]

8.262.400.12 CONTINUOUS ELIGIBILITY: An individual determined to be eligible for SCI will remain eligible, in the designated income grouping, for a period of twelve (12) continuous months, regardless of changes in income. The calculated premiums, copayments and cost-sharing maximum amounts will remain in effect for the benefit year following the eligibility determination.

[8.262.400.12 NMAC - N, 7-1-05]

8.262.400.13 ENROLLMENT: To

be considered enrolled in a given month, an individual must have notified the MCO of their selection and become enrolled though the MCO process, and the MCO must consider their premium(s) to be paid. Upon each positive eligibility determination, an enrollment letter will be issued, advising the individual that SCI coverage will begin upon completed enrollment with a SCI-contracted MCO. Each month, the MCO will provide a roster that includes each enrolled individual. Each SCI-contracted MCO will notify the individual and/or the employer of the owed premium amount for the ongoing month. If the premiums are not paid on time, the MCO will send advance notice of closure to the member, prior to termination of coverage due to nonpayment. The MCO will subsequently notify the individual of the termination and the requirements for reenrollment.
[8.262.400.13 NMAC - N, 7-1-05]

8.262.400.14 REENROLLMENT: Individual members who have been terminated due to failure to make premium payment or for late payment will be unable to reenroll for a period of six months subsequent to the first month of termination due to failure to make premium payments *and* until payment of late or defaulted premiums if so required by the MCO. Employer members who have been terminated due to failure to make premium payment or for late payment will be unable to reenroll for a period of twelve months subsequent to the first month of termination due to failure to make premium payments *and* until payment of late or defaulted premiums if so required by the MCO. As a condition of reenrollment an MCO may require an employer to repay overdue premiums as well as require two months premium payments in advance after termination due to nonpayment or late payment.
[8.262.400.14 NMAC - N, 7-1-05]

8.262.400.15 RESIDENCY: To be eligible for SCI, applicants/recipients must be living in New Mexico on the date of application or final determination of eligibility and have demonstrated an intention to remain in the state.

A. **Establishing residence:** Residence in New Mexico is established by living in the state and carrying out the types of activities normally associated with everyday life, such as occupying a home, enrolling child(ren) in school, getting a state driver's license, or renting a post office box. An applicant/recipient who is homeless is considered to have met the residence requirements if he intends to remain in the state.

B. **Abandonment of residence:** Residence is not abandoned by temporary absences. Temporary absences occur when recipients leave New Mexico for specific purposes with time-limited goals. Residence is considered abandoned when any of the following occurs:

(1) applicant/recipient leaves New Mexico and indicates that he intends to establish residence in another state;

(2) applicant/recipient leaves New Mexico for no specific purpose with no clear intention of returning;

(3) applicant/recipient leaves New Mexico and applies for financial, food, or medical assistance in another state that makes residence in that state a condition of eligibility; or

(4) applicant/recipient has been absent from New Mexico for more than thirty (30) days without notifying HSD of his departure or intention of returning.
[8.262.400.15 NMAC - N, 7-1-05]

8.262.400.16 CITIZENSHIP: Refer to 8.200.410.11 NMAC.
[8.262.400.16 NMAC - N, 7-1-05]

8.262.400.17 SPECIAL RECIPIENT REQUIREMENTS:

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

B. **Continuing eligibility on the factor of age:** When an individual has been determined eligible on the condition of age, he remains eligible on the condition until the applicable upper age limit is reached. An individual who exceeds the age limit during a given month is eligible for that month, unless the birthday is the first day of the month.

C. **Uninsured:** For purposes of SCI eligibility, an individual cannot have health insurance coverage under a commercial health care product, medicare, or other full-coverage medicaid category. An individual with access to health care at Indian health services, veteran's administration, or through worker's compensation, is not considered to be insured by having such access. An individual with only a catastrophic coverage plan is not considered to be insured.

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

E. **Premium payment**: SCI requires payment of premiums by the employer at a rate established by the department, and by the employee per month as calculated by income level, 062A-0, 062B and 062C. The individual is required to pay both the employers and employee's share based on income level. Nothing in this section prevents another entity from contributing the employer and/or employee premium share on behalf of an individual member. Nothing in this section prevents the employer from paying the employee portion of the premium on behalf of the employee.

F. **Voluntary drop of health insurance:** An individual who has voluntarily dropped health insurance will be ineligible for SCI for six months, starting with the first month the health insurance was dropped (i.e., the first month of no coverage). An employer who has voluntarily dropped health insurance will be ineligible to enroll employees in SCI for twelve months.

G. **Cost-sharing maximums:** An SCI-covered individual is responsible for tracking and reporting of the cost-sharing amount paid in a benefit year, and for reporting to the managed care organization (MCO) when the cost-sharing maximum amounts are met (also known as "shoebox methodology"). The first month of coverage without cost-sharing will be the month after the month of verification that the maximum expenditure limit has been met, unless the determination is made after the 24th of the month. Where the determination is made after the 24th of the month, the first month of coverage without cost-sharing will be the second month after verification. The period of coverage without cost-sharing will end on the last day of that benefit year.
[8.262.400.17 NMAC - N, 7-1-05]

8.262.400.18 RESIDENCE IN A PUBLIC INSTITUTION:

A. An applicant/recipient who is an inmate of a public institution is not eligible for New Mexico medicaid. A public institution is an institution that is the responsibility of a governmental unit and over which a governmental unit exercises administrative control [42 CFR 435.1009].

B. Public institutions include jails, prisons, detention centers, diagnostic holding centers, the New Mexico boys and girls schools, wilderness camps, or halfway houses and reintegration centers that are not certified to furnish medical care.

C. An individual is not considered to be living in an institution if he is placed in a detention center for a temporary period pending other arrangements appropriate to his needs. For purposes of medicaid eligibility, an individual who is placed in a detention center is considered temporarily absent from the home, until the 60th day, or the adjudication, whichever occurs first.
[8.262.400.18 NMAC - N, 7-1-05]

8.262.400.19 NON-CONCURRENT RECEIPT OF ASSISTANCE: An SCI applicant/recipient cannot be simultaneously approved for any of the other New

Mexico medicaid categories, or for any medicaid program in another state.
[8.262.400.19 NMAC - N, 7-1-05]

HISTORY OF 8.262.400 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 262 MEDICAID ELIGIBILITY - STATE COVERAGE INSURANCE (SCI) (CATEGORY 062)
PART 500 INCOME AND RESOURCE STANDARDS

8.262.500.1 ISSUING AGENCY: New Mexico Human Services Department.
[8.262.500.1 NMAC - N, 7-1-05]

8.262.500.2 SCOPE: The rule applies to the general public.
[8.262.500.2 NMAC - N, 7-1-05]

8.262.500.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2 authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) wavier under section 1115 of the Social Security Act, subject to special terms and conditions.
[8.262.500.3 NMAC - N, 7-1-05]

8.262.500.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver, and subject to availability of funds.
[8.262.500.4 NMAC - N, 7-1-05]

8.262.500.5 EFFECTIVE DATE: July 1, 2005, unless a later date is cited at the end of a section.
[8.262.500.5 NMAC - N, 7-1-05]

8.262.500.6 OBJECTIVE: The objective of the SCI program is to reduce the number of uninsured New Mexico residents by implementation of a basic coverage health insurance benefit provided by contracted managed care organizations (MCOs), with cost-sharing by beneficiaries, employers, and the state and federal governments.
[8.262.500.6 NMAC - N, 7-1-05]

8.262.500.7 DEFINITIONS: See 8.262.400.7 NMAC.
[8.262.500.7 NMAC - N, 7-1-05]

8.262.500.8 [RESERVED]

8.262.500.9 ESTABLISHING NEED - GENERAL REQUIREMENTS: Methodology for establishing financial eligibility for state coverage insurance (SCI) uses New Mexico works cash assistance definitions of income, rules for income availability, and exempt income.

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

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

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

D. **SCI category designation:** SCI eligibles will be assigned one category of eligibility (062) and one of three subcategories of SCI eligibility 062A-0-100% FPL; 062B-101-150% FPL; and 062C-151-200% FPL that are based on income level as determined at the time of application. The income grouping (subcategory) will control the premium and copayment amounts.
[8.262.500.9 NMAC - N, 7-1-05]

8.262.500.10 RESOURCES/PROPERTY - RESOURCE STANDARDS: There are no resource tests for the SCI program.
[8.262.500.10 NMAC - N, 7-1-05]

8.262.500.11 INCOME: In order to be eligible on the basis of income, countable income as determined in this section must be ***less*** than the income standard in effect for the SCI program. When income of an SCI applicant is exactly equal to the income standard, eligibility does not exist.
[8.262.500.11 NMAC - N, 7-1-05]

HISTORY OF 8.262.500 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 262 MEDICAID ELIGIBILITY - STATE COVERAGE INSURANCE (SCI) (CATEGORY 062)
PART 600 BENEFIT DESCRIPTION

8.262.600.1 ISSUING AGENCY: New Mexico Human Services Department.
[8.262.600.1 NMAC - N, 7-1-05]

8.262.600.2 SCOPE: The rule applies to the general public.
[8.262.600.2 NMAC - N, 7-1-05]

8.262.600.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter27, Articles 1and 2) authorize the state to administer the medicaid program. The state was granted a 5-year health insurance flexibility and accountability (HIFA) waiver under Section 1115 of the Social Security Act, subject to certain terms and conditions. The state is using the waiver authority to implement the State Coverage Insurance (SCI program). The SCI program offers a basic benefit package to adults with countable income of less than 200% of the federal poverty level. There is no fee-for-service coverage under SCI. The benefits begin after enrollment with one of the contracted managed care organizations.
[8.262.600.3 NMAC - N, 7-1-05]

8.262.600.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver, and subject to availability of funds.
[8.262.600.4 NMAC - N, 7-1-05]

8.262.600.5 EFFECTIVE DATE: July 1, 2005, unless a later date is cited at the end of a section.
[8.262.600.5 NMAC - N, 7-1-05]

8.262.600.6 OBJECTIVE: The objective of the SCI program is to reduce the number of uninsured New Mexico residents by implementation of a basic coverage health insurance benefit provided by contracted managed care organizations (MCOs), with cost-sharing by beneficiaries, employers, and the state and federal governments.
[8.262.600.6 NMAC - N, 7-1-05]

8.262.600.7 DEFINITIONS: See 8.262.400.7 NMAC.

8.262.600.8 [RESERVED]

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

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

B. The cost-sharing maximum is an amount calculated for the benefit year that represents an amount equal to 5% of the individual's countable income at the time of the application disposition. It is the responsibility of each SCI-covered individual to track and total the amounts paid for the SCI premiums and SCI co-payments on SCI-covered services in a benefit year. Once the cost-sharing maximum amount has been paid by an SCI-covered individual, the individual must notify the MCO and provide verification of the paid amounts. Once the paid amounts have been verified as paid, the individual will not owe further premium or co-payment amounts for the remainder of that benefit year. The first month that cost sharing is not required by the SCI-covered individual is the month following the month in which it has been verified by the MCO that the cost-sharing maximum amount has been met. If the determination is made after the twenty-fourth (24^{th}) of the month, the change is made effective the second month after the verification. No retroactive eligibility for the "met cost-sharing maximum" amount is allowed.

C. Employer share payable by individual: An individual member (one who is enrolled outside of an employer group) is responsible for payment of the premium share for the employee as determined by federal poverty level and the employer premium. These premiums will be counted as part of the calculation for co-payments and premiums to determine the cost-sharing maximum.
[8.262.600.9 NMAC - N, 7-1-05]

8.262.600.10 BENEFIT DETERMINATION: Benefits will begin when it is established that an individual has met all eligibility and enrollment criteria for a given month. Benefits will be issued only via the managed care contractor selected by the individual; there is no fee-for-service coverage. A member of an employer group who has met the cost sharing maximum amount will receive coverage without copayments or premiums for the employee share. The employer will retain responsibility for the employer portion of the premium for the remainder of the benefit year. An individual who is not part of an employer group and has met the cost-sharing maximum amounts will receive coverage without payment of premiums for both the employer and employee premium shares and co-payments for the remainder of that benefit year. If another entity has made cost-sharing payment on behalf of an individual, those "third party" paid amounts will not be counted toward the cost-sharing maximum.
[8.262.600.10 NMAC - N, 7-1-05]

8.262.600.11 CONTINUOUS ELIGIBILITY: Eligibility will continue for the twelve-month certification period, regardless of changes in income, as long as the individual retains New Mexico residency and continues to be ineligible for other medicaid or medicare coverage and is less than 65 years of age. Twelve-month continuous eligibility shall not be affected by the disposition of any other benefit(s) such as TANF, food stamps, etc. HSD will notify members, whether employees enrolled through an employer group or individuals, forty-five (45) days prior to the end of the recertification period. Members are responsible for recertifying eligibility within the forty-five (45) day period prior to expiration of the eligibility certification period and notifying the MCO or the employer of their interest in recertification.
[8.262.600.11 NMAC - N, 7-1-05]

8.262.600.12 RETROACTIVE BENEFIT COVERAGE: There is no retroactive eligibility under the SCI program. Benefits begin only after eligibility and enrollment criteria have been established for a given month.
[8.262.600.12 NMAC - N, 7-1-05]

8.262.600.13 APPEAL RIGHTS - BENEFITS AND ENROLLMENT ISSUES: See 8.306.12 NMAC. The MCO grievance/appeal process will be the mandatory first venue for issues of MCO action, enrollment, and verification of cost-sharing maximum amounts paid by SCI program participants.
[8.262.600.13 NMAC - N, 7-1-05]

8.262.600.14 APPEAL RIGHTS - ELIGIBILITY ISSUES: To appeal a denial or termination of SCI eligibility, or determination of the income grouping, the individual may request an administrative hearing from the human services department (see 8.352.2 NMAC).
[8.262.600.14 NMAC - N, 7-1-05]

8.262.600.15 APPEAL RIGHTS - LOSS OF ENROLLMENT DUE TO LATE PREMIUM PAYMENT OR FAILURE TO PAY THE PREMIUM: To appeal a loss of enrollment due to late premium payment or failure to pay the premium, an individual must file a grievance/appeal with the MCO. If the issue is not resolved at that level, the individual may appeal to the state district court at their own expense (see 8.352.2 NMAC).
[8.262.600.15 NMAC - N, 7-1-05]

HISTORY OF 8.262.600 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 1 GENERAL PROVISIONS

8.306.1.1 ISSUING AGENCY: Human Services Department
[8.306.1.1 NMAC - N, 7-1-05]

8.306.1.2 SCOPE: This rule applies to the general public.
[8.306.1.2 NMAC - N, 7-1-05]

8.306.1.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 subject to special terms and conditions.
[8.306.1.3 NMAC - N, 7-1-05]

8.306.1.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver, and subject to availability of funds.
[8.306.1.4 NMAC - N, 7-1-05]

8.306.1.5 EFFECTIVE DATE: July 1, 2005, unless a later date is cited at the end of a section.
[8.306.1.5 NMAC - N, 7-1-05]

8.306.1.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico state coverage insurance program.
[8.306.1.6 NMAC - N, 7-1-05]

8.306.1.7 DEFINITIONS: The state of New Mexico is committed to reducing the number of uninsured New Mexico residents and improving the number of small employers offering health benefit plans by implementation of a basic health

coverage health insurance benefit provided by contracted managed care organization with cost sharing by members, employers and the state and federal governments. This section contains the glossary for the New Mexico state coverage insurance policy. The following definitions apply to terms used in this chapter.

A. Definitions beginning with letter "A":

(1) **Abuse:** Provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary cost to SCI, in reimbursement for services that are not medically necessary, or in services that fail to meet professionally recognized standards for health care. Abuse also includes member or member practices that result in unnecessary costs to SCI.

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

(3) **Appeal:** A request from a member or provider for review of the managed care organization (MCO) action. Refers to an individual or entity appealing to a higher authority, as for a decision. An appeal is a request to change a previous decision made by the MCO. An appeal can be made to the contractor for review of a contractor action by a customer or a provider on a customer's behalf. An appeal may also be a request for a new hearing or a request for a transfer of a case from one court to a higher court.

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

B. Definitions beginning with letter "B":

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

(2) **Behavioral health:** Refers to mental health and substance abuse, including co-occurring disorders.

(3) **Behavioral health purchasing collaborative (the collaborative):** 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 15 direct service provision and funding agencies, including the human services department.

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

(5) **Benefit year:** The year beginning with the month of enrollment in an MCO and payment of designated premiums if applicable and continuing for a period of twelve continuous months as long as enrollment requirements are met.

(6) **Broker:** A person, partnership, corporation or professional corporation appointed by a health insurer licensed to transact business in New Mexico to act as its representative in any given locality for the purpose of soliciting and writing any policy or contract insuring against loss or expense resulting from the sickness of the insured.

C. Definitions beginning with letter "C":

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

(2) **Care coordination:** Is an office-based administrative function to assist members with multiple, complex and special cognitive, behavioral and/or physical health care needs on an as needed basis. It is member-centered, family-focused when appropriate, culturally competent and strengths-based. Care coordination can help to ensure that the physical and behavioral health needs of the SCI population are identified and services are provided and coordinated with the individual member and family, if appropriate. Care coordination operates within the MCO with a dedicated care coordination staff, functioning independently, but is structurally linked to the other MCO systems, such as quality assurance, member services, and grievances. Clinical decisions shall be based on the medically necessary covered services and not on fiscal considerations. If both physical and behavioral health conditions exist, the care coordination responsibility will lie with the care provider from the condition that is most acute at the time.

(3) **Case management**: Refers to a person or team of people who provide outreach to customers, provide information to them about services, work with them to develop a service plan, assist in obtaining needed services, supports and entitlements and advocate on their behalf. General case management is designed to access, coordinate and monitor services. It is a set of functions intended to ensure that individuals receive the services they need in a timely, appropriate, effective, efficient and coordinated fashion. It is individually centered, family/member-focused when appropriate, culturally competent and strengths-based. The general purposes of case management are to access, coordinate and monitor services and to assess an individual's progress toward specific goals. Services typically include assessment, plan of care/service plan, development and review, advocacy, referral and linkage to services, housing activities, the individual's income maintenance activities, facilitation and natural helping resources and coordination of physical health and social services and outcomes.

(4) **Category:** A designation of the automated eligibility system. SCI has one designated category (062) and three subcategories (062-A, 062-B, 062-C) that are assigned to an individual based on their income grouping. The assigned category is applicable for a period of 12 consecutive months regardless of changes in income or family status, subject to change by request from the recipient.

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

(6) **Client:** An individual who has applied for and been determined eligible for SCI. A "member" may also be referred to as a "member," "customer," or "consumer", or "program participant".

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

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

(9) **Cost-sharing:** Premiums and

co-payments owed by the member based on income group category.

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

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

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

D. Definitions beginning with letter "D":

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

(2) **Denial-administrative/technical:** A denial of authorization requests due to the requested procedure, service or item not being covered by SCI or due to provider noncompliance with administrative policies and procedures established by either the SCI MCO or the medical assistance division, except pharmaceutical services which the formulary process covers.

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

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

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

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

E. Definitions beginning with letter "E":

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

(2) **Employer:** An employer with fifty or fewer employees on a full or part time basis.

(3) **Employer group:** A group of employees employed by an eligible employer who receive SCI benefits through the employer.

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

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

(6) **Enrollee:** A SCI recipient who is currently enrolled in a managed care organization.

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

(8) **External quality review organization (EQRO):** An independent organization with clinical and health services expertise that is capable of reviewing health care delivery systems and their internal quality assurance mechanisms.

F. Definitions beginning with letter "F":

(1) **Family planning services:** Services provided to members of childbearing age to temporarily or permanently prevent or delay pregnancy (see 8.325.3 NMAC [MAD-762], *Reproductive Health Services*).

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

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

G. Definitions beginning with letter "G":

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

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

(3) **Grievance (provider):** Oral or written statement by a provider to the MCO regarding utilization management decisions and/or provider payment issues.

H. Definitions beginning with letter "H":

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

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

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

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

I. Definitions beginning with letter "I":

(1) **Income groupings:** 0-100%, 101-150%, and 151-200% of federal poverty levels: These income groupings define the premium, copayment, and cost-sharing maximums for SCI cost-sharing purposes.

(2) **Incurred but not reported (IBNR):** Claims for services authorized or rendered for which the MCO has incurred financial liability, but the claim has not been received by the MCO. This estimating

method relies on data from prior authorization and referral systems, as well as other data analysis systems.

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

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

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

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

M. Definitions beginning with letter "M":

(1) **Managed care organization (MCO):** An organization licensed or authorized through an agreement among state entities to manage, coordinate and receive payment for the delivery of specified services to enrolled members from a certain geographic area. Also referred to as a managed care plan and managed care program.

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

(3) **MCO appeal (member):** A request from a member or a provider, with the member's written consent, for review by the managed care organization (MCO) of an MCO action. An "MCO appeal" should not be confused with an applicant's or recipient's right to appeal an HSD fair hearing decision to state district court under the Public Assistance Appeals Act, NMSA 1978, Section 27-3-4 and pursuant to NMSA 1978, Section 39-3-1.1.

(4) **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.

(5) **Medically necessary services:**

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

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

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

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

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

(b) Application of the definition:

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

(ii) the MCO/SE making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the 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.

(6) **Member:** A eligible member enrolled in an MCO.

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

N. Definitions beginning with letter "N":

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

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

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

O. Definitions beginning with letter "O": **Outreach:** The act or process of promoting an insurance product through established business channels of communications including brochures, leaflets, internet, print media, electronic media, signage or other materials used by MCOs to attract or retain SCI enrollment primarily through employer groups.

P. Definitions beginning with letter "P":

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

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

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

(4) **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.

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

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

R. Definitions beginning with letter "R":

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

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

(3) **Reduction of care:** A utilization management staff authorization of the type of service requested by the provider but in lesser amounts or units of service, based on the member's physical health, medical or behavioral health clinical need, than was originally requested, except pharmaceutical services which are covered by

the formulary process.

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

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

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

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

S. Definitions beginning with letter "S":

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

(2) **SCI members with special health care needs (SCI-SHCN):** Individuals who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition, or low to severe functional limitation and who also require health and related services of a type or amount beyond that required by individuals.

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

(4) **Subcontract:** A written agreement between the MCO and a third party, or between a subcontractor and another subcontractor, to provide services.

(5) **Subcontractor:** A third party who contracts with the MCO or an MCO subcontractor for the provision of services.

T. Definitions beginning with letter "T":

(1) **Terminations of care:** The utilization management review decision made during a concurrent review, which yields a denial, based on the current service being no longer medically necessary, except pharmaceutical services, which are covered by the formulary process.

(2) **Third party:** An individual entity or program, which is or may be, liable to pay all or part of the expenditures for SCI members for services furnished.

U. Definitions beginning with letter "U": **Urgent condition:** Acute signs and symptoms, which, by reasonable medical judgment, represent a condition of sufficient severity such that the absence of medical attention within 24 hours could reasonably be expected to result in an emergency condition.
[8.306.1.7 NMAC - N, 7-1-05]

8.306.1.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.306.1.8 NMAC - N, 7-1-05]

HISTORY OF 8.306.1 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 2 MEMBER EDUCATION

8.306.2.1 ISSUING AGENCY: Human Services Department
[8.306.2.1 NMAC - N, 7-1-05]

8.306.2.2 SCOPE: This rule applies to the general public.
[8.306.2.2 NMAC - N, 7-1-05]

8.306.2.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act, subject to special terms and conditions.
[8.306.2.3 NMAC - N, 7-1-05]

8.306.2.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver, and subject to availability of funds.
[8.306.2.4 NMAC - N, 7-1-05]

8.306.2.5 EFFECTIVE DATE: July 1, 2005, unless a later date is cited at the end of a section.
[8.306.2.5 NMAC - N, 7-1-05]

8.306.2.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico state coverage insurance program.
[8.306.2.6 NMAC - N, 7-1-05]

8.306.2.7 DEFINITIONS: See 8.306.1.7 NMAC.
[8.306.2.7 NMAC - N, 7-1-05]

8.306.2.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.306.2.8 NMAC - N, 7-1-05]

8.306.2.9 MEMBER EDUCATION: SCI members shall be advised of their rights, responsibilities, service availability and administrative roles under SCI. Member education is initiated when a member becomes eligible for SCI with information provided by HSD and the managed care organization (MCO).

A. **Initial information:** Various outreach and media strategies are designed to reach employers, employees, as well as non-employed individuals; to ensure that all eligible New Mexicans are aware of the availability of SCI. Marketing is especially targeted to employers not currently offering insurance as well as to employers who offer insurance but whose employees cannot afford the required premium sharing. Initial member education is provided by the MCO and brokers and through outreach materials available from HSD.

B. **MCO enrollment information:** Once an individual enrollee or employee is determined to be eligible for the SCI program, his employer, broker, or MCO will provide the member information about services included in the MCO benefit package.

C. **Informational materials:** The MCO is responsible for providing members and potential members, upon request, a member handbook and a provider directory. The member handbook and the provider directory shall be available in languages other than English, if there is a greater than 5% incidence of another language spoken within the MCO membership as determined by the MCO or HSD.

(1) The member handbook shall include the following:

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

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

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

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

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

(f) description of benefits;

(g) information on accessing behavioral health or other specialty services,

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

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

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

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

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

(m) information regarding advance directives;

(n) information regarding obtaining a second medical opinion;

(o) information on cost sharing, cost sharing maximums and maximum benefit amounts per benefit year.

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

(2) The provider directory shall include the following:

(a) MCO addresses and telephone numbers;

(b) a listing of primary care and self-refer specialty providers with the name, location, phone number, and qualifications including areas of special expertise and non-English languages spoken; specialty providers for self-referral shall include, but not be limited to, family planning providers, point-of-entry behavioral health providers, urgent and emergency care providers, Indian health service, other Native American providers and pharmacies; and

(c) the material shall be available in a manner and format that can be easily understood by all populations who exceed a greater than 5% incidence in the total MCO membership as identified by the MCO and HSD.

D. **Other requirements:**

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

(2) The handbook and directory shall be provided in a comprehensive, understandable format that takes into consideration the special needs population, is in accordance with federal mandates and meets communication requirements delineated in 8.305.8.15 NMAC, *Member Bill of Rights*. This information may also be accessible via the internet.

(3) Oral and sign language interpretation shall be made available free of charge to members and to potential members, upon request, and be available in non-English languages for populations that exceed a greater than 5% incidence within the MCO's membership as defined by the MCO and HSD.

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

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

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

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

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

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

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

[8.306.2.9 NMAC - N, 7-1-05]

HISTORY OF 8.306.2 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 3 CONTRACT MANAGEMENT

8.306.3.1 ISSUING AGENCY: Human Services Department
[8.306.3.1 NMAC - N, 7-1-05]

8.306.3.2 SCOPE: This rule applies to the general public.
[8.306.3.2 NMAC - N, 7-1-05]

8.306.3.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act, subject to special terms and conditions.
[8.306.3.3 NMAC - N, 7-1-05]

8.306.3.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver, and subject to availability of funds.
[8.306.3.4 NMAC - N, 7-1-05]

8.306.3.5 EFFECTIVE DATE: July 1, 2005, unless a later date is cited at the end of a section.

[8.306.3.5 NMAC - N, 7-1-05]

8.306.3.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico SCI program.
[8.306.3.6 NMAC - N, 7-1-05]

8.306.3.7 DEFINITIONS: See 8.306.1.7 NMAC.
[8.306.3.7 NMAC - N, 7-1-05]

8.306.3.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.306.3.8 NMAC - N, 7-1-05]

8.306.3.9 ELIGIBLE MANAGED CARE ORGANIZATIONS: The human services department (HSD) shall award contracts to managed care organizations and other state entities that meet applicable requirements and standards 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. Risk-based contracts will be awarded to MCOs with statutory authority to assume risk. The physical and behavioral health services to be delivered under the terms of the contract are defined in 8.306.7 NMAC, *Benefit Package*.
[8.306.3.9 NMAC - N, 7-1-05]

8.306.3.10 CONTRACT MANAGEMENT:

A. **General contract requirements:** The MCOs shall meet all specified terms of the SCI contract and the Health Insurance Portability and Accountability Act (HIPAA). This includes, but is not limited to, insuring confidentiality as it relates to medical records and any other health and enrollment information that identifies a particular member. The MCO will be held harmless in conversion to HIPAA electronic transmission formats when delays are the result of implementation issues at HSD. HSD is responsible for management of the SCI managed care contracts issued to MCOs. HSD shall provide the oversight and administrative functions to ensure MCO compliance with the terms of the SCI managed care contract.

B. **Subcontracting requirements:** The MCO may subcontract to a qualified individual or organization the provision of any service defined in the benefit package or other required MCO function. The MCO shall be legally responsible to HSD for all work performed by any MCO subcontractor. The MCO shall submit boilerplate contract language and sample contracts for various types of subcontracts. Any substantive changes to contract templates shall be approved by HSD prior to issuance.

(1) **Credentialing requirements:** The MCO shall maintain policies and procedures for verifying that the credentials of its providers and subcontractors meet applicable standards.

(2) **Review requirements:** The MCO shall maintain a fully executed original of all subcontracts and make them available to HSD on request.

(3) **Minimum requirements:** Subcontracts shall contain the following provisions:

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

(b) subcontracts shall identify the parties of the subcontract and the parties' legal basis of operation 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 including a description of how members access services provided under the subcontract;

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

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

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

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

(i) subcontracts shall provide for the subcontractor to release to the MCO any information necessary to perform any of its obligations;

(j) the subcontractor shall accept payment from the MCO for any services provided under the benefit package and may not request payment from HSD for services performed under the subcontract;

(k) if the subcontract includes primary care, the subcontractor shall comply with PCP requirements in the MCO contract with HSD;

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

(m) the subcontract shall not prohibit a provider or other subcontractor from entering into a contractual relationship with another MCO;

(n) the subcontract shall allow providers to assist members to access the grievance process or to act to protect member interests; and

(o) the subcontract shall specify the time frame for submission of encounter data to the MCO.

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

C. **Provider incentive plans:** The MCO shall ensure that direct or indirect incentives offered in the subcontract shall not serve as an inducement to reduce or limit medically necessary services to members.
[8.306.3.10 NMAC - N, 7-1-05]

8.306.3.11 ORGANIZATIONAL REQUIREMENTS:

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

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

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

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

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

(1) **Review of policies and procedures:** The MCO shall review the

MCO's policies and procedures at least every two years, unless otherwise specified herein, to ensure that they reflect the MCO's current best industry practices. Job descriptions shall be reviewed to ensure that current employee duties reflect written requirements. Substantive modification or amendment to key positions shall be reviewed by HSD.

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

(3) **Business requirements:** The MCO shall have the administrative, information and other systems in place necessary to fulfill the terms of the SCI managed care contract. Any change in identified key MCO personnel shall conform to the requirements of the SCI managed care contract.

(4) **Financial requirements:** The MCO shall meet the requirements of federal and state law with respect to solvency and performance guarantees for the duration of the SCI managed care contract. The MCO shall meet additional financial requirements specified in the SCI managed care contract.

(5) **Member services:** The MCO shall have a member services function that coordinates communication with members and acts as a member advocate. Member services shall include sufficient staff to assist members in resolving problems or making inquiries. The MCO's policies and procedures shall be made available on request to members or member representatives for review during normal business hours.

(6) **Consumer advisory board:** The MCO shall establish representation on its current medicaid managed care consumer advisory board that includes SCI. This representation may have regional representation of customers, family members, advocates and providers who participate in SCI.

(a) Consumer advisory board members shall serve to advise the MCO on issues concerning service delivery and quality of service, the member bill of rights and member responsibilities, resolution of member grievances and the needs of groups represented by board member as they pertain to SCI.

(b) The MCO shall attend at least two statewide consumer-driven or hosted meetings per year, of the MCO's choosing, that focus on consumer issues and needs to ensure that member's concerns are heard and addressed.

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

(a) require plans of correction;

(b) impose directed plans of correction;

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

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

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

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

(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 SCI program; the state shall deduct from the penalty the amount of overcharge and return it to the affected enrollee; and

(d) rescind marketing consent;

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

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

(g) deny payment of capitation rates;

(h) assess actual damages;

(i) assess liquidated damages;

(j) remove members with third party coverage from enrollment with the MCO;

(k) allow members to terminate enrollment;

(l) suspend or terminate MCO contract;

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

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

(i) there is continued behavior by the MCO as described under sub-paragraph (c) above including but not limited to behavior that is prohibited under specific federal law granting states appropriations for medicaid services, 42 USC Sections 1396b(m) or 1396u-2; or

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

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

(iv) there shall be no provision for hearing prior to the imposition of temporary management and HSD shall not terminate temporary management until it determines that the MCO can ensure that the sanctioned behavior will not re-occur.

[8.306.3.11 NMAC - N, 7-1-05]

HISTORY OF 8.306.3 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 4 ELIGIBILITY

8.306.4.1 ISSUING AGENCY: Human Services Department
[8.306.4.1 NMAC - N, 7-1-05]

8.306.4.2 SCOPE: This rule applies to the general public.
[8.306.4.2 NMAC - N, 7-1-05]

8.306.4.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act, subject to special terms and conditions.
[8.306.4.3 NMAC - N, 7-1-05]

8.306.4.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver, and subject to availability of funds.
[8.306.4.4 NMAC - N, 7-1-05]

8.306.4.5 EFFECTIVE DATE: July 1, 2005, unless a later date is cited at the end of a section.
[8.306.4.5 NMAC - N, 7-1-05]

8.306.4.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico SCI program.
[8.306.4.6 NMAC - N, 7-1-05]

8.306.4.7 DEFINITIONS: See 8.306.1.7 NMAC.
[8.306.4.7 NMAC - N, 7-1-05]

8.306.4.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.306.4.8 NMAC - N, 7-1-05]

8.306.4.9 SCI ELIGIBILITY: HSD determines eligibility for enrollment in the SCI managed care program. All SCI eligible clients are required to participate in the SCI managed care program.
[8.306.4.9 NMAC - N, 7-1-05]

8.306.4.10 SPECIAL SITUATIONS: Clients 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 8.306.11.9 NMAC for special payment requirements.
[8.306.4.10 NMAC - N, 7-1-05]

8.306.4.11 MANAGED CARE STATUS CHANGE: A change of SCI eligibility for a member enrolled in an MCO may result in managed care disenrollment or change of enrollment status within the MCO.
[8.306.4.11 NMAC - N, 7-1-05]

HISTORY OF 8.306.4 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 5 ENROLLMENT

8.306.5.1 ISSUING AGENCY: Human Services Department
[8.306.5.1 NMAC - N, 7-1-05]

8.306.5.2 SCOPE: This rule applies to the general public.
[8.306.5.2 NMAC - N, 7-1-05]

8.306.5.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act, subject to special terms and conditions.
[8.306.5.3 NMAC - N, 7-1-05]

8.306.5.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver, and subject to availability of funds.
[8.306.5.4 NMAC - N, 7-1-05]

8.306.5.5 EFFECTIVE DATE: July 1, 2005, unless a later date is cited at the end of a section.
[8.306.5.5 NMAC - N, 7-1-05]

8.306.5.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico SCI program.
[8.306.5.6 NMAC - N, 7-1-05]

8.306.5.7 DEFINITIONS: See 8.306.1.7 NMAC.
[8.306.5.7 NMAC - N, 7-1-05]

8.306.5.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.306.5.8 NMAC - N, 7-1-05]

8.306.5.9 ENROLLMENT PROCESS:

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

B. **Member lock-in:** Except as otherwise provided below, once a member in an employer group has enrolled in an MCO through his employer group, he may only transfer to another MCO, 1) during the employer enrollment period, that occurs when the employer contracts with another MCO; or 2) if he changes employers. A member enrolled individually may only transfer to another MCO when his eligibility is recertified or "for cause" as defined as follows: the following criteria shall be cause for transfer:

(1) continuity of care issues;

(2) family continuity;

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

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

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

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

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

(8) other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs; if applicable, the member shall be notified by the MCO, 60 days prior to the expiration of the member's lock-in period of the deadline for selecting a new MCO; members in an employer group will be notified of the employer enrollment period by the employer or the broker, if applicable; members who are not in an employer group will be notified of the expiration of their lock-in period by the MCO.

C. **Selection period:** After receiving a letter of eligibility, a new individual member shall complete enrollment with an MCO within a thirty day period. If enrollment, including payment of applicable premium, if any, is not made within that timeframe, the member shall be considered to have voluntarily dropped the SCI insurance coverage, which means the individual, may not enroll with an SCI MCO for six months. An employer group has a specified time period, determined by the MCO and HSD, in which to complete enrollment and premium payment with an SCI MCO after all employees have received their letters of eligibility. Failure of the employer to complete the enrollment process within this time period will deem the employer to have voluntarily dropped insurance coverage and ineligible to enroll with an SCI MCO for a twelve-month period.

D. **Beginning date of enrollment:** Enrollment begins the first day of the first full month following receipt of eligibility letter and MCO completion of enrollment including receipt of required premiums. However, if MCO receipt of premium payment occurs after the 25th day of the month and before the first full day of

the following month, the enrollment begins on the first day of the second full month after MCO receipt of premium payments.

E. **Member switch enrollment:** A member enrolled as an individual and not as an employee enrolled through an employer group may request to be disenrolled from an MCO and switch to another MCO (if available) "for cause" at any time. The request shall be made in writing to HSD. HSD shall review the request and furnish a written response to the member and the MCO in a 30 day period. The following criteria shall be used to make a decision regarding a switch enrollment request:

(1) continuity of care issues;

(2) family continuity;

(3) administrative or data entry error in enrolling a member with an MCO; and

(4) travel for primary care exceeds community standards, (90% of urban residents shall travel no further than 30 miles to see a PCP; 90% of rural residents shall travel no further than 45 miles to see a PCP; and 90% 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.

F. **Disenrollment, MCO initiated:** The MCO may request that a particular member be disenrolled. Other than for non-payment of premiums, member disenrollment from an MCO will be considered only in rare circumstances. Disenrollment requests shall be made in writing to HSD. The MCO shall notify the member in writing of the disenrollment request at the same time the request is submitted to HSD. The MCO shall submit a copy of the member's notification letter to HSD. If the disenrollment is granted, the MCO retains responsibility for the member's care until the member is enrolled with another SCI- contracted MCO. If the member is part of an employer group and the employer does not contract with another MCO, HSD may allow the member to enroll with another MCO, but the member shall be responsible for the employer's premium share. The MCO shall assist with transition of care to the other MCO.

G. **Conditions under which an MCO requests member disenrollment:** The MCO may not seek to terminate enrollment because of an adverse change in the member's health. The MCO shall not request disenrollment because of an adverse change in the member's health status or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his special needs, except when his continued enrollment with the MCO seriously impairs the MCO's ability to furnish services to either this particular member or other members. The MCO shall notify the member in writing of the disenrollment request at the same time the request is submitted to HSD. The MCO shall submit a copy of the member's notification letter. If the disenrollment is granted, the MCO retains responsibility for the member's care until the member is enrolled with another MCO. The MCO shall assist with transition of care.

H. **Re-enrollment limitations:** If a request for disenrollment is approved, the member shall not be re-enrolled with the requesting MCO for a period of time to be determined by HSD. The member and the requesting MCO shall be notified by HSD of the period of disenrollment. If a member has been disenrolled by all available contracted MCOs, HSD shall evaluate the member for termination from SCI.

I. **Date of disenrollment:** MCO enrollment shall terminate at the end of the month following the month in which HSD approval for disenrollment is granted.
[8.306.5.9 NMAC - N, 7-1-05]

8.306.5.10 ENROLLMENT ROSTERS: The MCO shall submit a monthly roster to HSD by the 24th of the month with, at minimum, the ID number of members; identifying who is enrolled; the status of premium payment, if applicable, who is to be disenrolled and the reason for disenrollment; the effective dates of enrollment; members' names, addresses, social security numbers, according to a format provided by HSD. HSD will verify the roster against the state eligibility file. If any discrepancies are found, an error report is generated and HSD staff shall communicate with the MCO and/or income support division (ISD) staff to resolve any discrepancies. The MCO shall resubmit any necessary corrections, working with SCI staff if necessary, before the end of the month. HSD sends a final enrollment roster to the MCO based on all verified members identified by the cutoff date.
[8.306.5.10 NMAC - N, 7-1-05]

8.306.5.11 MEMBER SELECTION: A new SCI member selects an MCO prior to applying for eligibility from HSD. Once an MCO is selected, the employer/employee or individual is instructed by the MCO or designee to download eligibility application forms from the SCI website or obtain an application form from a designated outreach center. The application together with required verification documents will be sent to an ISD office. The ISD office shall process the application within the 45 day time frame specified by ISD regulation and generate a letter of eligibility to the member or a letter of denial of eligibility along with the appropriate fair hearing information. The eligibility determination will only be sent to the individual/employee. An employer shall obtain the letter of eligibility from his employee to complete the employer group application process.
[8.306.5.11 NMAC - N, 7-1-05]

8.306.5.12 MEMBER IDENTIFICATION CARD: The MCO shall issue a member identification card within 30 days of enrollment to each member. The card shall be substantially the same as the card issued to commercial enrollees. The card shall not contain information that identifies the member as an SCI member, other than designations commonly used by MCOs to identify for providers the members' benefits, such as group or plan numbers or co-payment amounts.
[8.306.5.12 NMAC - N, 7-1-05]

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

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

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

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

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

C. **Member selection period:** Following a mass transfer, MCO members or employers as applicable are given an opportunity to select a different MCO, if available.

D. **Mass transfer based on significant change in contracting status:** The mass transfer function is triggered when the MCO's contract status changes and the change may be significant to the MCO member. Upon initiation of the mass transfer function by HSD, MCO members are transferred to a different MCO and notice is sent to members informing them of the transfer and their opportunity to select a different MCO, if available. HSD will work with employers to contract with the new MCO(s).

[8.306.5.13 NMAC - N, 7-1-05]

8.306.5.14 SCI MARKETING-OUTREACH GUIDELINES: When marketing to SCI members, MCOs shall follow the SCI marketing guidelines.

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

(1) marketing and outreach materials shall meet requirements for all communication with SCI members, as required in the quality standards (8.305.8.15 NMAC, *Member Bill of Rights*) and incorporated into the managed care contract;

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

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

(4) if there is a population of greater than 5% in the MCO membership, as identified by the MCO and HSD, that has limited English proficiency, as identified by the MCO or HSD, marketing materials shall be available in the language of that population; and

(5) other requirements specified by the state.

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

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

(2) contain language or information designed to attract SCI enrollment.

C. **Advertising and marketing material:** Medicaid-specific advertising and marketing materials, including materials disseminated by a sub-contractor and information disseminated via the Internet requires HSD approval. In reviewing this information, HSD shall apply a variety of criteria.

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

(2) **Misleading references:** Misleading information about the MCO shall not be allowed even if it is accurate.

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

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

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

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

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

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

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

(7) conducting any other marketing activity prohibited by HSD,

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

(9) distributing any marketing materials without first obtaining HSD approval;

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

(11) engaging in door-to-door, telephone or other cold call marketing activities, directly or indirectly; and

(12) other requirements specified by HSD.

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

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

G. **Member-initiated meetings with MCO staff prior to enrollment:** Face-to-face meetings requested by members are permitted. These meetings may occur at a mutually agreed upon site.

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

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

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

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

L. **Gifts to members at health milestones unrelated to enroll-**

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

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

[8.306.5.14 NMAC - N, 7-1-05]

HISTORY OF 8.306.5 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 6 PROVIDER NETWORKS

8.306.6.1 ISSUING AGENCY: Human Services Department

[8.306.6.1 NMAC - N, 7-1-05]

8.306.6.2 SCOPE: This rule applies to the general public.

[8.306.6.2 NMAC - N, 7-1-05]

8.306.6.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act, subject to special terms and conditions.

[8.306.6.3 NMAC - N, 7-1-05]

8.306.6.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver, and subject to availability of funds.

[8.306.6.4 NMAC - N, 7-1-05]

8.306.6.5 EFFECTIVE DATE: July 1, 2005, unless a later date is cited at the end of a section.

[8.306.6.5 NMAC - N, 7-1-05]

8.306.6.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico SCI program.

[8.306.6.6 NMAC - N, 7-1-05]

8.306.6.7 DEFINITIONS: See 8.306.1.7 NMAC.

[8.306.6.7 NMAC - N, 7-1-05]

8.306.6.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.

[8.306.6.8 NMAC - N, 7-1-05]

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

A. **Service coverage:** The MCO shall provide or arrange for the provision of services described in 8.306.7 NMAC, *Benefit Package* prior to contract start date. The MCO is solely responsible for the provision of covered services and shall ensure that its network includes providers in sufficient numbers and required specialists to make all services included in the package available and in accordance with access standards as specified herein and in 8.305.8.18*, Medicaid Managed Care Quality Management Standards for Access*.

B. **Comprehensive network:** The MCO shall contract with the full array of providers necessary to deliver a level of care at least equal to, or better than, community norms. The MCO shall contractually require that all network providers and subcontractors be in compliance with the Health Insurance Portability and Accountability Act (HIPAA). In establishing and maintaining the network of appropriate providers, the MCO shall consider the following:

(1) the numbers of network providers who are accepting new SCI members;

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

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

C. **Maintenance of provider network:** The MCO shall notify HSD within five working days of unexpected changes to the composition of its provider network that negatively affects members' access or the MCO's ability to deliver services included in the benefit package in a timely manner. Anticipated material changes in an MCO provider network shall be reported to HSD in writing when the MCO knows of the anticipated change or within 30 calendar days, whichever comes first. A notice of significant change shall contain:

(1) the nature of the change;

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

(3) the MCO's plan for maintaining access and the quality of member care.

D. **Required policies and procedures:** The MCO shall maintain policies and procedures on provider recruitment and termination of provider participation with the MCO. The recruitment policies and procedures shall describe how an MCO responds to a change in the network that affects access and its ability to deliver services in a timely manner. The MCO:

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

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

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

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

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

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

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

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

E. **General information submitted to HSD:** The MCO shall maintain an accurate list of contracted, subcontracted, pending and terminated PCPs, specialists, hospitals and other providers participating or affiliated with the MCO. The MCO shall submit the list to HSD on a monthly basis and include a clear delineation of all additions and terminations that have occurred since the last submission.

[8.306.6.9 NMAC - N, 7-1-05]

8.306.6.10 PROVIDER QUALIFICATIONS AND CREDENTIALING: The MCO shall verify that each contracted or subcontracted provider, practitioner and

facility, participating in, or employed by, the MCO meets applicable federal and state requirements for licensing, certification, accreditation and recredentialing for the type of care or services within the scope of practice as defined by federal medicaid statutes and state law.
[8.306.6.10 NMAC - N, 7-1-05]

8.306.6.11 UTILIZATION OF OUT-OF-STATE PROVIDERS: To the extent possible, the MCO is encouraged to utilize in-state and border providers, which are defined as those providers located within 100 miles of the New Mexico border, Mexico excluded. The MCO may include out-of-state providers in the network.
[8.306.6.11 NMAC - N, 7-1-05]

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

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

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

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

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

(4) requiring PCPs contracted with the MCO to vaccinate members in their offices and not refer members elsewhere for immunizations;

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

(6) following MCO established procedures for coordination of services for members with providers participating in the MCO network; and

(7) the MCO shall develop and implement policies and procedures governing how coordination with the PCP will occur with hospitals that require in-house staff to examine or treat members having outpatient or ambulatory surgical procedures performed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) **Subsequent change in PCP initiated by member:** Members may initiate a PCP change at any time, for any reason. The request for PCP change may be made in writing or by telephone. If the change is requested by the 20th day of the month it will become effective the first day of the following month. If the request is made after the 20th day it will become effective the first day of the second month following the request.

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

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

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

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

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

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

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

[8.306.6.12 NMAC - N, 7-1-05]

8.306.6.13 SPECIALTY PROVIDERS:

A. The MCO shall be responsible for monitoring PCP actions to ensure compliance with MCO and HSD policies. The MCO shall communicate with and educate PCPs about special populations and their service needs. The MCO shall ensure that PCPs are successfully identifying and referring members to specialty providers as medically necessary. The MCO shall contract with a sufficient number of specialists with the applicable range of expertise to ensure that the anticipated needs of MCO members will be met within the MCO network of providers. The MCO shall have a system to refer members to providers who are not affiliated with the MCO network if providers with the necessary qualifications or certifications to provide the required care do not participate in the MCO's network.

B. The MCO shall have written policies and procedures for the arrangement and documentation of all referrals. The MCO policies and procedures shall designate the process used by the MCO to ensure that referrals for all medically necessary services are available to members. The MCO 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 I of 8.305.11.9 NMAC, *Reimbursement for Women in the Third Trimester of Pregnancy*.)

D. The MCO or a specialist may initiate a change of specialists when the member's/guardian's behavior toward the specialist is such that it has made all reasonable efforts to accommodate the member /guardian and address the member's problems, but those efforts have been unsuccessful

[8.306.6.13 NMAC - N, 7-1-05]

8.306.6.14 ACCESS TO SERVICES: The MCO shall demonstrate that its network is sufficient to meet the health care needs of enrolled members. HSD initially assesses the sufficiency of this network and then throughout the contract period. The MCO shall notify HSD of any changes in the MCO network. Changes affecting member access to care shall be communicated to HSD and remedied by the MCO in an expeditious manner.

A. **Provider to member ratios:**

(1) **PCP to member ratios:** The MCO shall ensure the member caseload of any PCP in its network does not exceed 1,500 SCI enrollees. Exceptions to this limit may be made with the consent of the MCO and HSD. Reasons for exceeding the limit may include continuation of established care, 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 MCO shall ensure that members have adequate access to specialty services.

B. **Compliance with specified access standards:** The MCO shall comply with all access standards delineated under the terms of the SCI contract with respect to geographic location, scheduling time and waiting times.

C. **Requirements for MCO policies and procedures:** The MCO shall maintain written policies and procedures describing how members and providers receive instructions on access to 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, network providers and members.

[8.306.6.14 NMAC - N, 7-1-05]

8.306.6.15 FAMILY PLANNING PROVIDERS: The MCO shall maintain 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 MCO shall ensure its policies and procedures for accessing family planning services meet specified requirements for member communication.

[8.306.6.15 NMAC - N, 7-1-05]

8.306.6.16 PROVIDER EDUCATION AND COMMUNICATION: The MCO shall establish and maintain policies and procedures governing the development and distribution of education and informational materials regarding SCI to its network providers. Policies and procedures shall:

A. inform providers of the conditions of participation with the MCO regarding SCI;

B. inform providers of their responsibilities to the MCO and to SCI members;

C. inform providers of SCI-specific policies and procedures;

D. furnish providers with policies and procedures regarding cultural competency and provide ongoing educational opportunities for providers and their staff on cultural competency;

E. provide information on credentialing and re-credentialing, prior authorization and referral processes and how to request and obtain a second opinion; and

F. provide information on the MCO's internal provider grievance process, by which providers can express their dissatisfaction with the plan's actions and file a complaint.

G. the MCO may conduct an annual provider satisfaction survey, the results of which will be incorporated into the MCO's quality improvement (QI) program; survey results will be forwarded to HSD.

H. the MCO shall actively solicit input from its network providers in an effort to improve and resolve problem areas related to the SCI program; the information provided will be incorporated into the MCO's QI program.

I. the MCO shall be able to provide HSD evidence, when requested, of all provider educational activities; evidence of such activities may include: a provider education schedule of events; provider manuals distributed to contracted providers and updated at least quarterly; publications, such as brochures and newsletters; or media, such as films, videotaped presentations, seminars; and schedules of classroom instruction; the MCO shall maintain and continue these activities with its network providers, including behavioral health, throughout the term of the MCO provider contractual relationship.

[8.306.6.16 NMAC - N, 7-1-05]

HISTORY OF 8.306.6 NMAC: [RESERVED]

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NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 7 BENEFIT PACKAGE

8.306.7.1 ISSUING AGENCY: Human Services Department
[8.306.7.1 NMAC - N, 7-1-05]

8.306.7.2 SCOPE: This rule applies to the general public.
[8.306.7.2 NMAC - N, 7-1-05]

8.306.7.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act, subject to special terms and conditions.
[8.306.7.3 NMAC - N, 7-1-05]

8.306.7.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver, and subject to availability of funds.
[8.306.7.4 NMAC - N, 7-1-05]

8.306.7.5 EFFECTIVE DATE: July 1, 2005, unless a later date is cited at the end of a section.
[8.306.7.5 NMAC - N, 7-1-05]

8.306.7.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico SCI program.
[8.306.7.6 NMAC - N, 7-1-05]

8.306.7.7 DEFINITIONS: See 8.306.1.7 NMAC.
[8.306.7.7 NMAC - N, 7-1-05]

8.306.7.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.306.7.8 NMAC - N, 7-1-05]

8.306.7.9 BENEFIT PACKAGE: This part defines the state coverage insurance (SCI) benefit package for which the MCO will be paid fixed payment rates. The MCO shall cover these services. The MCO shall not delete benefits from the SCI-defined benefit package. An MCO is encouraged to provide an enhanced benefit package, which could include health-related educational, preventive, outreach and enhanced physical and behavioral health services. The MCO may utilize providers licensed in accordance with state and federal requirements to deliver services.
[8.306.7.9 NMAC - N, 7-1-05]

8.306.7.10 SCI HEALTH BENEFITS: This part contains a detailed explanation of the services covered by SCI, limitations and exclusions to covered services, and services that are not covered by SCI. The MCOs shall determine their own utilization management (UM) protocols, which are based on reasonable medical evidence and are not subject to the utilization management protocols in the medical assistance program manual. HSD may review the MCO's UM protocols.
[8.306.7.10 NMAC - N, 7-1-05]

8.306.7.11 SERVICES INCLUDED IN THE SCI BENEFIT PACKAGE: The SCI benefit package includes provider and consultation services and supplies that are reasonably required to maintain good health and are provided by or under the direction of the member's PCP. The following lists covered services and provides additional information.

A. **Provider services**:

(1) office visits;

(2) home visits;

(3) hospital and inpatient physical rehabilitation facility visits by physician;

(4) inpatient and outpatient surgery (includes assistant surgeon's charges);

(5) office procedures;

(6) inpatient professional care services, including pathologists, radiologists and anesthesiologists;

(7) allergy testing;

(8) allergy injections;

(9) antigen serum;

(10) injections in accordance with accepted medical practice to treat acute conditions, which are customarily administered in a provider's office;

(11) injections in accordance with acceptable medical practice used to treat chronic conditions, including, but not limited to, diseases such as rheumatoid arthritis, crohn's disease, and hepatitis C; and

(12) routine and diagnostic x-rays and clinical laboratory tests.

B. **Inpatient hospital services:** The benefit package includes inpatient hospital services as detailed below.

(1) Hospital admissions must have prior authorization and are to be provided under the direction of the member's PCP or a consulting provider to whom the member is referred by his PCP. Any service or procedure not outlined below requires a prior authorization.

(2) Inpatient hospitalization coverage is limited to twenty-five (25) days per benefit year. This twenty-five (25)-day limitation is combined with home health services and inpatient physical rehabilitation.

(3) Inpatient hospital services include:

(a) semi-private room and board accommodations, including general duty nursing care;

(b) private room and board accommodations when medically necessary; prior authorization is required;

(c) in-hospital therapeutic and support care, services, supplies and appliances, including care in specialized intensive and coronary care units;

(d) use of all hospital facilities, including operating, delivery, recovery, and treatment rooms and equipment;

(e) laboratory tests, x-rays, electrocardiograms (EKGs), electroencephalograms (EEGs), and other diagnostic tests performed in conjunction with a member's admission to a hospital;

(f) anesthetics, oxygen, pharmaceuticals, medications, and other biological;

(g) dressings, casts, and special equipment when supplied by the hospital for use in the hospital;

(h) inpatient meals and special diets;

(i) inpatient radiation therapy and/or inhalation therapy;

(j) rehabilitative services - physical, occupational, and speech therapy;

(k) administration of whole blood, blood plasma, and components;

(l) discharge planning and coordination of services; and

(m) maternity care.

C. **Outpatient services:** The benefit package includes outpatient services performed in a hospital or other approved outpatient facility. Outpatient services:

(1) can reasonably be provided on an ambulatory basis;

(2) are preventive, diagnostic or treatment procedures provided under the direction of the member's PCP or a consulting provider to whom the member is referred by the PCP;

(3) require prior authorization, unless otherwise noted; and

(4) the following provides additional information on covered outpatient services and associated co-payments:

(a) surgeries, including use of operating, delivery, recovery, treatment rooms, equipment and supplies, including anesthesia, dressings and medications;

(b) radiation therapy and chemotherapy;

(c) magnetic resonance imaging (MRI);

(d) positron emission tomography (PET) tests;

(e) CT scan;

(f) holter monitors and cardiac event monitors;

(g) routine and diagnostic x-rays, clinical laboratory tests, electrocardiograms (EKGs), and electroencephalograms (EEGs);

(h) cardiovascular rehabilitation; and

(i) rehabilitative services - physical, occupational, and speech therapy; rehabilitative services for short-term physical, occupational, and speech therapies are covered; short-term therapy includes therapy services that produce significant and demonstrable improvement within a two-month period from the initial date of treatment; the member's PCP or other appropriate treating provider to whom the member has been referred shall determine in advance of rehabilitative services that these services can be expected to result in significant improvement in the member's physical condition within a period of two months; requests for rehabilitative services from therapists will not be approved; these services shall be requested by the ordering provider and require a prior authorization.

(i) Extension of short-term therapy beyond the initial two months may be extended for one period of up to two months, contingent on the approval of the MCO'S medical director, only if such services can be expected to result in continued significant improvement of the member's physical condition within the extension period. Expectation of significant improvement will be established if the member has complied fully with the instructions for care and has met all therapy goals for the preceding two-month period as documented in the therapy record.

(ii) Therapy services extending beyond the two-month period from the initial date of treatment are considered long-term therapy and are not covered under SCI. Long-term therapy includes treatment for chronic or incurable conditions for which rehabilitative services produce minimal or temporary change or relief. Chronic conditions include, but are not limited to, muscular dystrophy, cerebral palsy, developmental delay, myofascial pain disorders, arthritis, autism, and syndromes of chromosomal abnormalities.

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

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

(2) the hospital contacted the MCO but did not get instructions within an hour of the request; the following provides additional information on covered services and required co-payments.

(a) Emergency health services can be provided in or out of the service area. Coverage is provided for trauma services at an appropriately designated trauma center according to established emergency medical services triage and transportation protocols.

(i) Prior authorization is not required for emergency care.

(ii) Coverage for trauma services and all other emergency health services from non-participating providers will continue at least until the member is medically stable, does not require critical care, and can be safely transferred to another facility based on the judgment of the attending participating provider in consultation with the MCO. The MCO may transfer hospitalized members to the care of participating providers as soon as it is medically appropriate. Such members shall be stabilized and the transfer effected in accordance with federal law.

(iii) The member is responsible for charges for non-covered services.

(b) Use of an urgent care center, where available, in or out of the service area for treatment of sudden unexpected acute illness or injury that requires prompt medical attention to prevent jeopardy to the member if such services were not received immediately.

(i) A non-participating urgent care center may be used only if the member cannot reasonably access a participating provider.

(ii) Routine or follow-up medical treatment shall be provided by or through a participating provider.

E. **Women's health services:** The benefit package includes any gynecological examinations or care related to pregnancy, for primary and preventive obstetrics, and gynecological services required as a result of any gynecological examination or condition. Covered women's health services may be obtained from the member's PCP, or a participating women's health care provider or a consulting provider to whom the member has been referred by her PCP. The following lists covered services and provides additional information.

(1) office visits;

(2) low-dose mammography screening for detection of breast cancer;

(3) cytological screening to determine the presence of pre-cancerous or cancerous conditions or other health problems; and

(4) services related to the diagnosis, treatment and appropriate management of osteoporosis.

F. **Prenatal and post-partum care:** Prenatal care includes a minimum of one prenatal office visit per month during the first two trimesters of pregnancy; two (2) office visits per month during the seventh and eight months of pregnancy; and one (1) office visit per week during the ninth month until tremor as medically indicated, provided that coverage for each office visit shall include prenatal counseling and education.

(1) Following delivery of a newborn, a female member is entitled to either:

(a) post-partum care in the home consisting of up to three visits; or

(b) a minimum hospital stay of specified inpatient hours. The choice of either home care or inpatient care will be made based on discussion between the participating provider and the member.

(2) If post-partum home care is elected, the care shall be rendered in accordance with accepted maternal and neonatal physician assessments, and by a home care participating provider who is properly licensed, trained and experienced. A maximum of three home care visits are allowable.

(3) If inpatient care is elected, a mother and her newborn child in a health care facility will be entitled to a minimum stay of 48 hours following a vaginal delivery or 96 hours following a caesarian section.

(4) Non- hospital births - prior authorization is required.

G. **Preventive health services:** The benefit package includes preventive health services. Preventive health services are provided to a member when performed by or under the direction of the member's PCP or a participating provider to whom the member has been referred by his

PCP, and are consistent with the MCO'S preventive health guidelines. The following lists covered services and provides additional information.

(1) Physical exams, including health appraisal exams, laboratory and radiological tests, hearing and vision screenings, and early detection procedures.

(2) Periodic tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or a fractionated cholesterol level

(3) Periodic glaucoma eye tests for all persons thirty-five (35) years of age and older

(4) Periodic stool examination for the presence of blood for all persons 40 years of age or older

(5) Periodic mammograms for detection of breast cancer as follows: one low dose baseline mammogram for women ages 35 through 39, one low dose mammogram bienially for women ages 40 through 49 and one low dose mammogram annually for women over age 50.

(6) All members may receive an annual consultation to discuss lifestyle behaviors that promote health and well-being. The consultation may include, but not be limited to:

(a) smoking control;

(b) nutrition and diet recommendations;

(c) exercise plans;

(d) lower back protection;

(e) immunization practices;

(f) breast self-examinations;

(g) testicular self-examinations; or

(h) use of seat belts in motor vehicles.

(7) Adult immunizations in accordance with the recommendations of the advisory committee on immunization practices (ACIP).

(8) Periodic colon examination of thirty-five (35) to sixty (60) centimeters and/or barium enema for all persons forty-five (45) years of age or older.

(9) Voluntary family planning services.

(10) Insertion of contraceptive devices.

(11) Removal of contraceptive devices.

(12) Surgical sterilization.

(13) Pregnancy termination procedures: The benefit package includes services for the termination of pregnancy and pre or post-decision counseling or psychological services as detailed in 8.325.7 NMAC, *Pregnancy Termination Procedures.*

H. **Dialysis:** The benefit package includes dialysis services. Long-term hemodialysis and continuous ambulatory peritoneal dialysis (CAPD) is provided with a prior authorization and performed by or under the direction of the member's PCP or a consulting provider to whom the member has been referred by his PCP. The member shall advise the MCO of the date the treatment commenced.

I. **Inpatient physical rehabilitation:** The benefit package includes inpatient physical rehabilitation. The following lists covered services and provides additional information.

(1) Inpatient physical rehabilitation services require prior authorization, and services are to be provided under the direction of the member's PCP or a consulting provider to whom the member is referred by his PCP.

(2) Inpatient physical rehabilitation facility coverage is limited to twenty-five (25) days per benefit year. This twenty-five (25)-day limitation is combined with inpatient hospital and home health services.

J. **Home health services/home intravenous services:** The benefit package includes home health services, which are health services provided to a member confined to his home due to physical illness. The following lists covered services and provides additional information.

(1) Home health services and home intravenous services are provided by a home health agency (HHA) at a member's home with a prior authorization and prescribed by the member's PCP or a consulting provider to whom the member is referred by his PCP.

(2) Home health services in lieu of hospitalization are limited to twenty-five (25) days per benefit year provided that a period of inpatient hospitalization coverage shall precede any home health care coverage or the PCP shall provide a statement indicating that inpatient hospitalization would be necessary in the absence of home health services. This twenty-five (25) day limitation is combined with inpatient hospitalization and inpatient physical rehabilitation.

(3) Services provided by a registered nurse or a licensed practical nurse; by physical, occupational, and respiratory therapists; speech pathologists; or by a home health aide are covered.

(4) Prescription supplies for the provision of home health services at the time of a home health visit are covered.

(5) Home intravenous services are covered.

(6) Tube feedings as the sole source of nutrition are covered.

K. **Durable medical equipment, medical supplies, orthotic appliances and prosthetic devices:** The benefit package includes durable medical equipment, medical supplies, orthotic appliances, and prosthetic devices. The following lists covered services and provides additional information.

(1) Prior authorization is required.

(2) Durable medical equipment, medical supplies, orthotic appliances and prosthetic devices with allowable charges of $200 or more per item, including tax and any shipping charges are covered. Rental price cannot exceed purchase price.

(3) Durable medical equipment that requires a provider's prescription for purchase or rental is covered unless otherwise excluded.

(4) Medical supplies that require a provider's prescription for purchase are covered unless otherwise excluded.

(5) Orthotic appliances that require a provider's prescription for purchase are covered unless otherwise excluded.

(6) Prosthetic devices are covered only when they replace a limb or other part of the body after accidental or surgical removal and/or when the body's growth or atrophy necessitates replacement, unless otherwise excluded.

(7) Breast prostheses and bras required in conjunction with reconstructive surgery are covered, except as limited.

(8) Repair or replacement of durable medical equipment, orthotic appliances and prosthetic devices due to normal wear and/or when necessitated by the body's growth or atrophy are covered.

L. **Ambulance services:** The benefit package includes emergency transport services identified below.

(1) When necessary to protect the life of the mother or infant, emergency transport includes transport for medically high-risk pregnant women with an impending delivery to the nearest tertiary care facility.

(2) The MCO will not pay more for air ambulance than it would have paid for transportation over the same distance by surface emergency medical transportation services unless the member's health condition renders the utilization of such surface services medically inappropriate.

(3) Emergency ground ambulance transportation to the nearest facility where emergency care and treatment can be rendered and when provided by a licensed ambulance service

(4) Emergency, trauma-related air ambulance transportation - prior authorization is required, when feasible.

M. **Oral surgery:** The benefit package includes limited oral surgery benefits with prior authorization. The following lists covered services and provides additional information. General dental and oral surgery services with a prior authorization only in conjunction with:

(1) Accidental injury to sound natural teeth, the jawbones, or surrounding

tissues, treatment for injury is covered when initial treatment for the injury is sought within seventy-two (72) hours of the injury. Teeth with crowns or restorations are not considered to be sound natural teeth. The injury shall be properly documented during the initial treatment. Services shall be completed within twelve (12) months of the date of injury. The MCO will require dental x-rays.

(2) Surgical procedures to correct non-dental, non-maxillomandibular physiologic conditions that produce demonstrable impairment of function are covered.

(3) Removal or biopsy, when pathological examination is required of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth are covered.

(4) External incision and drainage of cellulitis; incision of infected accessory sinuses, salivary glands or ducts; and removal of stones from salivary ducts are covered.

(5) Surgical procedures to correct accidental injuries of the jaws and facial bones, cheeks, lips, tongue, roof and floor of mouth are covered.

N. **Reconstructive surgery:** The benefit package includes reconstructive surgery as provided below:

(1) Reconstructive surgery from which an improvement in physiological function can be expected if performed for the correction of functional disorders - prior authorization is required. Functional disorder shall result from accidental injury or from congenital defects or disease.

(2) Prosthetic devices and reconstruction surgery of the affected breast or other breast to produce symmetry related to mastectomy. This coverage includes physical complications at all stages of mastectomy, including lymph edemas. A member is allowed at least forty-eight (48) hours of inpatient care following mastectomy and twenty four (24) hours of inpatient care following a lymph node dissection for the treatment of breast cancer.

O. **Prescription drugs:** The benefit package includes all generic prescription drugs and brand name drugs included on the MCO'S preferred drug list (PDL). Exceptions to the PDL depend on MCO policy.

P. **Diabetes treatment:** The benefit package includes diabetes treatment. The MCO will maintain an adequate PDL to provide resources to members with diabetes; and guarantee reimbursement or coverage for prescription drugs, insulin, supplies, equipment and appliances with a prior authorization described in this subsection within the limits of the MCO. The following lists covered services and provides additional information.

(1) Equipment, supplies and appliances to treat diabetes to include:

(a) blood glucose monitors, including those for the legally blind;

(b) test strips for blood glucose monitors;

(c) visual reading urine and ketone strips;

(d) lancets and lancet devices;

(e) insulin (limit two (2) vials per co-payment);

(f) injection aids, including those adaptable to meet the needs of the legally blind;

(g) syringes;

(h) prescriptive oral agents for controlling blood sugar levels;

(i) medically necessary podiatric appliances for prevention of foot complications associated with diabetes, including therapeutic molded or depth inlay shoes, functional orthotic appliances, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment; and

(j) glucagons emergency kits.

(2) Diabetes self-management training by a certified, registered or licensed health care professional with recent education in diabetes management, which is limited to:

(a) medically necessary visits upon the diagnosis of diabetes;

(b) visits following a provider diagnosis that represents a significant change in the member's symptoms or condition that warrants changes in the member's self-management;

(c) visits when re-education or refresher training is prescribed by a health care provider with prescribing authority; and

(d) medical nutrition therapy related to diabetes management.

Q. **Behavioral health and substance abuse services:** The benefit package includes behavioral health and substance abuse services. Inpatient behavioral health services are limited to twenty-five (25) days per benefit year with prior authorization.

(1) **Behavioral health service:**

(a) Outpatient office visits for mental health evaluation and treatment; injectable forms of haloperidol or fluphenazine are included in the office visit co-payment. Prior authorization is required for over seven (7) visits.

(b) Inpatient mental health services provided in a psychiatric hospital or an acute care general hospital - *prior authorization is required*.

(2) **Substance abuse service:**

(a) outpatient substance abuse including visits, detoxification and intensive outpatient care limited to forty two (42) days per benefit year; and

(b) inpatient substance abuse detoxification - *prior authorization is required.*

R. **Annual limits on out-of-pocket expenditures:** Out-of-pocket charges for all participants will be limited to 5 percent of maximum gross family income per benefit year. Pharmacy out-of-pocket charges for all participants will be limited to $12 per month.

S. **Limitations on coverage:** The benefit package is limited to $100,000 in benefits payable per member per benefit year.

[8.306.7.11 NMAC - N, 7-1-05]

8.306.7.12 COVERED SERVICES AND SERVICE LIMITATIONS: The SCI benefit package is limited to $100,000 in benefits payable per member per benefit year. Covered services are subject to the following conditions and limitations:

A. **Medically necessary:** Medically necessary services are clinical and rehabilitative physical, mental or behavioral health services that:

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

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

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

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

B. Behavioral health and substance abuse services:

(1) Inpatient mental health services/partial hospitalizations are limited to twenty-five (25) days per benefit year.

(2) Inpatient substance abuse detoxification is limited to 72 hours per occurrence as part of the total twenty-five day benefit for inpatient mental health services.

(3) Outpatient substance abuse detoxification services are limited to ten (10) days per benefit year. Substance abuse outpatient services including intensive outpatient services are limited to forty-two (42) days per benefit year.

C. **Cardiovascular rehabilitation:** Coverage for cardiovascular rehabilitation is limited to a maximum of thirty-six (36) sessions per cardiac event.

D. **Choice of provider:** For the purpose of coverage under this policy, the SCI MCO has the right to determine

which provider may be used to provide the covered services.

E. **Contact lenses or eyeglasses following cataract surgery:** One complete set of contact lenses or eyeglasses is covered following surgery for the removal of cataracts from one or both eyes. Coverage is not allowed for both contact lenses and eyeglasses. Coverage is limited to one set of contact lenses or eyeglasses per member per surgery. Coverage for materials (contact lenses or eyeglasses) is limited to $300 per surgery. Coverage for contact lenses or eyeglasses is limited to ninety (90) days following surgery for the removal of cataracts. Contact lenses or eyeglasses obtained after the ninety (90) day period are not covered.

F. **Dental services:** In cases of accidental injury to sound natural teeth, the jawbones, or surrounding tissues, treatment for injury is covered when initial treatment for the injury is sought within seventy-two (72) hours of the injury. Teeth with crowns or restorations are not considered to be sound natural teeth. The injury shall be properly documented during the initial treatment. Services shall be completed within twelve (12) months of the date of injury. The MCO will require dental x-rays.

G. **Detoxification:** Inpatient detoxification is limited to seventy-two (72) hours of inpatient services per occurrence as part of the twenty-five day benefit for inpatient behavioral health services. Outpatient detoxification is limited to ten (10) days per benefit year.

H. **Home health services:** Home health services in lieu of hospitalization, or a combination of inpatient hospitalization, home health services and inpatient rehabilitation, may not exceed twenty-five (25) days per benefit year, provided that a period of inpatient hospitalization coverage shall precede any home health care coverage or the PCP shall provide a statement indicating that inpatient hospitalization would be necessary in the absence of home health services. Home health services are subject to periodic review of the continuation of covered services. If home health services can be provided in more than one medically appropriate setting, the MCO may choose the setting for providing the care.

I. **Inpatient hospitalization, home health services, inpatient rehabilitation:** This policy is limited to maximum of twenty-five (25) combined days per member per benefit year for inpatient hospitalization, home health services and inpatient rehabilitation.

J. **Major disasters:** In the event of any major disaster, epidemic, or other circumstance beyond its control, the MCO will render or attempt to arrange covered services with participating providers insofar as practical according to its best judgment and within the limitations of facilities, supplies, pharmaceuticals, and personnel available. Such circumstances include: complete or partial disruption of facilities; war; riot; civil uprising; disability of the MCO personnel; disability of participating providers; or act of terrorism.

K. **Maximum benefit limits:** Maximum benefits allowed under SCI are limited to $100,000 per member per benefit year.

L. **Maternity transport:** Coverage for transportation where medically necessary to protect the life of the infant or mother, including air transport if indicated for medically high risk pregnant women with an impending delivery of a potentially viable infant to the nearest available tertiary care center.

M. **Mastectomy and lymph node dissection:** Length of inpatient stay: not less than forty eight (48) hours inpatient stay following a mastectomy and not less than twenty four (24) hours of inpatient care following a lymph node dissection when determined medically appropriate by physician and patient.

N. **Orthotic appliances and prosthetic devices:** Repair or replacement of orthotic appliances and prosthetic devices due to normal wear is covered.

O. **Physical, speech and occupational therapy:** Only short-term rehabilitative services are covered. Short-term therapy is limited to no more than two (2) consecutive months per member per condition.

P. **Post mastectomy supplies:** Bras required in conjunction with reconstructive surgery are limited to two (2) per member, per benefit year.

Q. **Prescription drugs:** Prescription drugs are limited to generic drugs and name brand prescriptions on the preferred drug list (PDL) drugs as listed on the MCO PDL. For each co-payment amount, quantities are limited to a thirty (30)-day supply or one hundred (100) tablets; whichever is less, per prescription or refill. All other units will be dispensed in a thirty (30)-day supply, with one co-payment required for each of the following quantities:

(1) **Topical products:** The lesser of eighty (80) gm. of cream/ointment or sixty (60) ml. of lotion/solution or the most commonly dispensed trade package size, per co-payment.

(2) **Oral liquids:** 480 ml. maximum per co-payment.

(3) **Inhalers and vials:** One (1) co-payment per unit (diabetic insulin exception - two (2) vials of the same type of insulin per co-payment).

(4) **Manufacturer's trade package:** One (1) co-payment per trade package (i.e. imitrex, estrogen patches).

(5) **Mail order drugs** are limited to drugs available through the MCO'S mail order distributor.

R. **Transplants - organ, bone marrow, and/or tissue:**

(1) Organ, bone marrow, and/or tissue transplants are limited to:

(a) heart;

(b) heart/lung;

(c) lung;

(d) liver;

(e) cornea;

(f) kidney;

(g) skin;

(h) bone marrow (allogenic and autologous stem cell rescue only for leukemia, aplastic anemia, severe combined immunodeficiency disease, wiskott-aldrich syndrome, advanced hodgkin's or non-hodgkin's lymphoma, recurrent or refractory neuroblastoma, and multiple myelomas); or

(i) pancreas (for uremic, insulin-dependent diabetics concurrently receiving a kidney transplant).

(2) No other transplant procedures are covered. The MCO has the right to require that transplants be performed at contracted centers of excellence if one is available.

(3) A member is eligible for coverage for up to two (2) transplants per lifetime. Multiple organ, bone marrow, and/or tissue transplants performed at the same time are considered to be one procedure. All transplant services are limited by the $100,000 annual benefit limitation per member per benefit year.

[8.306.7.12 NMAC - N, 7-1-05]

8.306.7.13 SERVICES EXCLUDED FROM THE SCI BENEFIT PACKAGE: SCI does not cover any service or supply not specifically listed in 8.306.7.12 NMAC as a covered service. If a service is not a covered service, then all services performed in conjunction with the non-covered service are not covered as well. The list of exclusions below is not intended to be exhaustive. If a service is not listed in 8.306.7.12 NMAC as a covered service, then it is not covered regardless of medical necessity. Other services excluded are:

A. **Services not coordinated through a member's PCP or lack of a prior authorization:** Health services and supplies if not provided by or under the direction of:

(1) the member's PCP or a provider to whom the member has been referred by his PCP;

(2) a non-participating provider to whom the member has been referred by his PCP, and a prior authorization is in place for those services; or

(3) any services or supplies that require a prior authorization if a prior authorization is not obtained.

B. **Services not medically necessary, not standard medical practice, or experimental:** The following services are not covered:

(1) any treatment, procedure, facility, equipment, drug, drug use, device, or supply that is not medically necessary; SCI pays only for medically necessary services furnished by approved providers to eligible recipients; SCI does not cover experimental or investigational medical, surgical, or other health care procedures or treatments, including the use of drugs, biological products, other products or devices except routine patient costs associated with certain Phase I, II III and IV cancer clinical trials;

(2) drugs and devices that are not FDA approved, not FDA approved for the proposed use, or that have been voluntarily removed from the market; and

(3) medical, surgical, and/or behavioral health procedures, pharmacological regimes, and/or associated health services if they are experimental, under investigation, or generally not standard medical practice.

C. **Acupuncture and chiropractic services:** Acupuncture and chiropractic services are not covered.

D. **Assistant surgeon services:** Assistant surgeon services are not covered if not approved by the MCO.

E. **Behavioral health:** The following behavioral health services are not covered: behavioral health services that are rendered in connection with disorders not classified in the international classification of diseases, 9th revision, clinical modification (ICD-9-CM). Behavioral health services that are not inpatient hospitalizations or outpatient visits including, but not limited to, residential treatment services, treatment foster care, day treatment, and neurobehavioral programs.

F. **Cosmetic services:** Cosmetic services are not covered, including but not limited to: surgery, services, or procedures to change family characteristics or conditions due to aging; dermabrasion; scar reconstruction or revision; acne surgery (including excision of scarring and cryotherapy); tattoo removal; orthognathic jaw surgery; services performed in connection with the enlargement, reduction, implantation, or change in appearance of a portion of the body; surgical excision or reformation of sagging skin on any part of the body including, but not limited to eyelids, face, neck, abdomen, arms, legs or buttocks; microphlebectomy; sclerotherapy; liposuction; rhinoplasty; otoplasty; services related to a cosmetic service, or required as a result of a noncovered cosmetic service; surgery required as a result of a noncovered procedure (such as a noncovered organ/tissue transplant or a sex change operation) or additional surgery or treatment required to care for or correct a complication due to a previous cosmetic service; or breast augmentation, reduction mammoplasty, or nipple reconstruction except as related to reconstructive surgery.

G. **Court ordered care:** Court-mandated evaluations and treatment that would not be in compliance with the terms and conditions of the MCO contract are not covered.

H. **Coverage out of the service area:** Coverage while away from service area, except for emergency health services and urgently needed health services, is not included unless otherwise covered.

I. **Custodial care:** Custodial or home (domestic) care, including services and supplies that can be performed by non-licensed medical personnel to help a member meet the normal activities of daily living are not covered. Examples of custodial care that are not covered services are:

(1) bathing;

(2) feeding;

(3) preparing meals; and

(4) performing housekeeping tasks.

J. **Dental services:** The following dental services are not covered:

(1) All general dental services and dental x-rays, including but not limited to:

(a) anesthesia and facility services for dental restoration;

(b) removal of impacted teeth;

(c) removal of tori or exostoses;

(d) procedures involving orthodontic care, the teeth, dental implants and periodontal disease;

(e) artificial devices, surgery on the supporting structures of the teeth, and bone grafts to prepare the mouth for denture wear;

(f) personalized restorations, cosmetic replacement of serviceable restorations, or materials that are more expensive than necessary to restore damaged teeth; or

(g) surgical realignment of the jaw structures for functional malocclusion.

(2) Orthodontics, endodontics, and dental prosthetics.

(3) Orthotic and orthodontic appliances and/or treatment, crowns, bridges, and/or dentures used for the treatment of craniomandibular and temporomandibular joint disorders.

K. **Donor services:** Medical and hospital services of a donor when the recipient of an organ, bone marrow, and/or tissue transplant is not a member, or when the transplant procedure is not a covered service are not included in the benefit package.

L. **Durable medical equipment, medical supplies; prosthetic devices; orthotic appliances:** The following are not included in the benefit package:

(1) **Durable medical equipment, medical supplies:**

(a) equipment that is non-medical in nature such as voice synthesizers or other communication devices, waterbeds, jacuzzi units, hot tubs, whirlpools, swimming pools, exercise equipment, heating pads, or hot water bottles;

(b) air conditioners, humidifiers, purifiers, or self-help devices, biofeedback equipment, and tens units;

(c) deluxe equipment, such as motor-driven wheelchairs, chairlifts, or beds, when standard equipment is available and adequate to meet functional requirements;

(d) repairs to equipment that is not owned by the member, or repairs to equipment that exceeds the rental price of another unit for the estimated period of need or that exceeds the purchase price of a new unit;

(e) comfort or safety items such as bed boards, hospital beds or mattresses, flotation mattresses, bathtub lifts, grab bars, over bed tables, adjustable beds, telephone arms, diapers, under pads;

(f) sphygmomanometers, stethoscopes, and blood pressure monitors; or

(g) medical supplies and equipment that can be purchased over the counter such as shower chairs, elevated toilet seats, alcohol pads, and dressing supplies.

(2) **Prosthetic devices:**

(a) prosthetic devices unless they replace a limb or other part of the body after accidental or surgical removal and/or when the body's growth or atrophy necessitates replacement;

(b) external prosthetic devices that are suited for heavier physical activity such as fast walking, jogging, bicycling, or skiing;

(c) cosmetic coverings for external prosthetic devices;

(d) repairs of prosthetic devices that are not owned by the member; or

(e) cochlear implants.

(3) **Orthotic appliances:**

(a) accommodative orthotic appliances; orthopedic shoes and shoe orthotic appliances (except when the shoes are attached and an integral part of the brace), arch supports, shoe inserts, special-ordered shoes, custom shoes, built up shoes of any type, and other supportive devices for the feet, except for the management of diabetes as required by law;

(b) orthopedic appliances that can be purchased over-the-counter;

(c) cranial banding services; or

(d) penile prosthesis.

M. **Eyeglasses and vision**

services: The following eyeglasses and vision services are not included in the benefit package:

(1) eye refractions, eyeglasses, and contact lenses, and/or the fitting thereof, and routine vision services, except for contact lenses or eyeglasses following cataract surgery; and

(2) surgical procedures for the correction of visual acuity in lieu of eyeglasses or contact lenses, except for intraocular lenses in connection with cataract removal.

N. **Genetic testing:** Genetic testing, screening (other than by triple serum test only) and counseling, with the exception of genetic testing for the diagnosis or treatment of a current illness are not included in the benefit package.

O. **Health clubs:** Fees for health clubs, spas and exercise programs are not included in the benefit package.

P. **Hearing aids:** The purchase of hearing aids, and/or the fitting thereof, associated hearing aid testing, and other artificial aids, is not included except as specifically defined in Subsection G of 8.306.7.11 NMAC, *Preventive Health Services*.

Q. **Hospice care:** Hospice care is not included in the benefit package.

R. **Illegal acts or crimes:** The following is not covered: Injury or illness sustained during the voluntary participation in a riot or the commission of an illegal act or crime, or while under the influence of alcohol or other drug or controlled substance, which is not prescribed by a provider. For purposes of this Subsection, a person will be presumed to be under the influence of alcohol or other drug or controlled substance if objective evidence suggests such condition, as determined pursuant to the reasonable exercise of discretion by the MCO. The limitations of this subsection will not apply unless there is a direct causal relationship between the activity described above and the illness or injuries sustained.

S. **Infertility treatment:** Infertility treatment services are not covered.

T. **Learning disorders:** Special education, counseling, therapy, diagnostic testing, or treatment for learning disorders, whether or not associated with a mental disorder, retardation, or other disturbance, are not included in the benefit package.

U. **Marital therapy or counseling:** Marital therapy or counseling is not covered.

V. **Missed appointments:** Costs incurred in conjunction with missed appointments are not included in the benefit package.

W. **Modifications, improvements, equipment:** Home, workplace, and automobile modifications, improvements, or equipment are not included in the benefit package.

X. **No legal obligation to pay:** The following are not included in the benefit package:

(1) services a member is eligible to receive and has received under any governmental program which, in the absence of any health services or insurance plan, no charge would be made to the member; and

(2) services or supplies for which the member has no legal obligation to pay or for which no charge would be made if the member were not eligible for SCI.

Y. **Paternity tests:** Diagnostic tests to establish paternity of a child or unborn child are not included in the benefit package.

Z. **Physical examinations:** The following physical examinations are not included in the benefit package:

(1) routine physical examinations, vaccinations, and/or immunizations if given for:

(a) the purpose of obtaining employment, insurance, passports, or travel; or

(b) for the purpose of medical research.

(2) sports and school physicals, unless done in conjunction with periodic health assessments.

AA. **Physical, speech, occupational therapy - long term:** All long-term physical, speech and occupational therapy services are not included in the benefit package.

BB. **Physical, speech, occupational therapies:** Physical, speech, occupational therapies for the following conditions are not covered:

(1) psychosocial speech delay including delayed language development and developmental apraxia;

(2) mental retardation, down's syndrome, autism, autism spectrum disorders, or dyslexia;

(3) syndromes associates with diagnosed disorders attributed to perceptual and conceptual dysfunctions;

(4) learning disabilities, developmental articulation and language disorders, and stuttering; and

(5) sensory disorders (oral and tactile aversions).

CC. **Podiatry and foot care:** The benefit package does not include podiatry or foot care, including but not limited to: bunion treatment, callus treatment, corn paring or excision, toenail trimming, except in the treatment of insulin-dependent diabetics. Foot massage of any type, treatment of fallen arches, flat or pronated feet, and shock wave treatment are not included in the benefit package.

DD. **Prenatal, delivery, post-partum services:**

(1) **All services related to the prenatal period:** Delivery and post-partum services shall be received in the MCO service area.

(2) Tests to determine the gender of an unborn child are excluded from coverage.

EE. **Prescription drugs:** The following are excluded from coverage:

(1) brand name non-PDL prescription drugs without prior approval;

(2) drugs that do not require a physician's prescription; except insulin;

(3) contraceptive jellies, creams, foams, devices or implants (except legend contraceptive devices);

(4) therapeutic devices or appliances;

(5) drugs whose sole purpose is to promote or stimulate hair growth (e.g., Rogaine®, Propecia®) or for cosmetic purposes only (e.g., Renova®);

(6) biologicals, blood or blood plasma products;

(7) drugs labeled "caution - limited by federal law to investigational use" or experimental drugs, even though a charge is made to the individual;

(8) medication for which the cost is recoverable under any workers' compensation or occupational disease law or from any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the member;

(9) medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution, which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals;

(10) any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order; and

(11) charges for the administration or injection of any drug.

FF. **Pulmonary rehabilitation:** Pulmonary rehabilitation is not included in the benefit package.

GG. **Recovery:** Services and supplies that are otherwise covered, to the extent that a member realizes a recovery from any source, are not included in the benefit package.

HH. **Repair or replacement for lost, stolen, or damaged Items:** Repair or replacement for lost, stolen, or damaged items listed below are not included in the benefit package:

(1) durable medical equipment;
(2) medical supplies;
(3) orthotic appliances;
(4) prosthetic devices; and
(5) prescription drugs.

II. **Services, supplies for excluded services:** Services, supplies, or drugs used for non-covered or excluded procedures or treatment, or used for any related complication(s) are not included in the benefit package.

JJ. **Services, supplies not primarily medical:** Services, supplies, and self-help items that are not primarily medical in nature, for personal comfort or safety, convenience or beautification during an inpatient stay, or in the home setting are not covered. Examples include but are not limited to: facial tissues, shampoo, diapers, under pads, grab bars, and exercise equipment.

KK. **Sex transformation:** Sex transformation surgery and all expenses in connection with such surgery are not included in the benefit package.

LL. **Sexual dysfunction:** Treatment for sexual dysfunction, including medication, counseling, and clinics, is not included in the benefit package.

MM. **Sterilization reversal:** Any service related to reversal of sterilization is not included in the benefit package.

NN. **Substance abuse and/or tobacco use:** Treatment to prevent the following is not included in the benefit package:

(1) inpatient substance abuse treatment other than detoxification; and

(2) nicotine medications, gums, services, or supplies to aid in the treatment of addiction to tobacco or tobacco products; nicotine withdrawal treatments, including hypnosis, biofeedback, guided imagery, and other forms of relaxation training or subliminal suggestions used to modify tobacco use.

OO. **Therapies:** Therapies including, but not limited to: exercise, massage, hypnotherapy, sensory, hippo, aquatic, oral aversion, visual training, recreational, sleep, stress management, scream, and myotherapy are not included in the benefit package.

PP. **Travel/lodging expenses:** Travel and lodging expenses are not included in the benefit package.

QQ. **Vocational rehabilitation services:** Vocational rehabilitation services are not included in the benefit package.

RR. **War, terrorism, armed forces:** Any illness and/or injury resulting from war, act of terrorism, or an act of war or service in the armed forces of any country are not included in the benefit package, to the extent covered services of such illness and/or injury are provided through any governmental plan or program.

SS. **Weight loss:** Surgery, medications, and related services for the purpose of weight reduction or control are not included in the benefit package.

TT. **Worker's compensation:** Industrial, work-related, or occupational illnesses, injuries, or conditions subject to federal, state, or other workers' compensation or liability law or other legislation of similar purpose are not included in the benefit package, unless the group is an employer not subject to the New Mexico Workers' Compensation Act or similar legislation.

UU. **Miscellaneous:** The following miscellaneous items are not included in the benefit package:

(1) charges associated with copying or transferring of health information;

(2) consultations by environmental engineers;

(3) devices, medications, and treatments to remove hair due to excessive hair growth;

(4) holistic medicine and/or biofeedback;

(5) treatments, medications, prosthetic devices, and orthotic appliances to treat hair loss;

(6) bone density screening with ultrasound devices; and

(7) telephone visits by a provider or environmental intervention or consultation by telephone for which a charge is made to the member, and getting acquainted visits without physical assessment or diagnostic or therapeutic intervention provided.

[8.306.7.13 NMAC - N, 7-1-05]

HISTORY OF 8.306.7 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 8 QUALITY MANAGEMENT

8.306.8.1 ISSUING AGENCY: Human Services Department
[8.306.8.1 NMAC - N, 7-1-05]

8.306.8.2 SCOPE: This rule applies to the general public.
[8.306.8.2 NMAC - N, 7-1-05]

8.306.8.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act, subject to special terms and conditions.
[8.306.8.3 NMAC - N, 7-1-05]

8.306.8.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver, and subject to availability of funds.
[8.306.8.4 NMAC - N, 7-1-05]

8.306.8.5 EFFECTIVE DATE: July 1, 2005, unless a later date is cited at the end of a section.
[8.306.8.5 NMAC - N, 7-1-05]

8.306.8.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico SCI program.
[8.306.8.6 NMAC - N, 7-1-05]

8.306.8.7 DEFINITIONS: See 8.306.1.7 NMAC.
[8.306.8.7 NMAC - N, 7-1-05]

8.306.8.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.306.8.8 NMAC - N, 7-1-05]

8.306.8.9 QUALITY MANAGEMENT: HSD recognizes that strong programs of quality improvement and assurance help ensure that better care is delivered in a cost-effective manner to the member. Under the terms of the medicaid managed care contracts, quality management programs are incorporated into health care delivery and administrative systems. SCI prefers, but does not require NCQA accreditation for MCOs. The SCI program will require compliance with portions of 8.305.8 NMAC, *Quality Management,* as they apply to the SCI adult (19-64) population, as follows: 8.305.8.10 NMAC, *External Quality Review*; 8.305.8.11 NMAC, *Broad Standards*; 8.305.8.12 NMAC, *Standards for Quality Management and Improvement*; 8.305.8.13 NMAC, *Standards for Utilization Management*; 8.305.8.14 NMAC, *Standards for Credentialing and Recredentialing*; 8.305.8.15 NMAC, *Member Bill of Rights*; 8.305.8.16 NMAC, *Standards for Preventive Health Services*; with the exception of Paragraph 13 and 14 of Subsection C of 8.305.8.16 NMAC, *Newborn Screening* and *Tot-to-Teen Health Checks*; 8.305.8.17 NMAC, *Standards for Medical Record*; and 8.305.8.18 NMAC, *Standards for Access*.
[8.306.8.9 NMAC - N, 7-1-05]

8.306.8.10 DELEGATION:

Delegation is a process whereby an MCO gives another entity the authority to perform certain functions on its behalf. The MCO is fully accountable for all delegated activities and decisions made. The MCO shall document its oversight of the delegated activity. The MCO shall delegate behavioral health functions and activities, which may include: quality oversight, utilization management prevention, education, outreach, grievance resolution, data collection and claims payment to the contracted single statewide entity (SE).

A. A mutually agreed upon document between the MCO and the delegated entity will describe:

(1) the responsibilities of the MCO and the entity to which the activity is delegated;

(2) the delegated activity;

(3) the frequency and method of reporting to the MCO;

(4) the process by which the MCO evaluates the delegated entity's performance; and

(5) the remedies up to, and including, revocation of the delegation, available to the MCO if the delegated entity does not fulfill its obligations.

B. The MCO shall document evidence that the MCO:

(1) evaluated the delegated entity's capacity to perform the delegated activities prior to delegation;

(2) evaluates regular reports; and

(3) evaluates semi-annually the delegated entity's activities in accordance with the MCO's expectations and HSD standards.

[8.306.8.10 NMAC - N, 7-1-05]

HISTORY OF 8.306.8 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 9 COORDINATION OF BENEFITS

8.306.9.1 ISSUING AGENCY: Human Services Department
[8.306.9.1 NMAC - N, 7-1-05]

8.306.9.2 SCOPE: This rule applies to the general public.
[8.306.9.2 NMAC - N, 7-1-05]

8.306.9.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 subject to special terms and conditions.
[8.306.9.3 NMAC - N, 7-1-05]

8.306.9.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver, and subject to availability of funds.
[8.306.9.4 NMAC - N, 7-1-05]

8.306.9.5 EFFECTIVE DATE: July 1, 2005, unless a later date is cited at the end of a section.
[8.306.9.5 NMAC - N, 7-1-05]

8.306.9.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico state coverage insurance program.
[8.306.9.6 NMAC - N, 7-1-05]

8.306.9.7 DEFINITIONS: See 8.306.1.7 NMAC.
[8.306.9.7 NMAC - N, 7-1-05]

8.306.9.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.306.9.8 NMAC - N, 7-1-05]

8.306.9.9 COORDINATION OF BENEFITS:

A. The MCO shall develop and implement policies and procedures to ensure access to care coordination for individuals with special health care needs (ISHCN) as defined in 8.306.15.9 NMAC. Care coordination is defined as a service to assist clients with special health care needs, on an as needed basis. It is member-centered, family-focused when appropriate, culturally competent and strength-based. Care coordination can help to ensure that the medical and behavioral health needs of the SCI population are identified and services are provided and coordinated with all service providers, individual members and family if appropriate. Care coordination operates within the MCO with a dedicated care coordination staff functioning independently but is structurally linked to the other MCO systems, such as quality assurance, member services and grievances. Clinical decisions shall be based on the medically necessary covered services and not fiscal considerations. If both physical and behavioral health conditions exist, the care shall be coordinated between both physical and behavioral health staff, and the responsibility for the care coordination shall be based upon what is in the best interest of the member.

B. The MCO shall use the following primary elements for care coordination:

(1) identify proactively the eligible populations;

(2) identify proactively the needs of the eligible population;

(3) provide a designated person as primarily responsible for coordinating the health services furnished and to serve as the single point of contact for the member;

(4) communicate to the member the care coordinator's name and how to contact him/her;

(5) ensure access to a qualified provider who is responsible for developing and implementing a comprehensive treatment plan as per applicable provider regulations;

(6) ensure the provision of necessary services and actively assist members and providers in obtaining such services;

(7) ensure appropriate coordination between physical and behavioral health services and non-managed care services;

(8) coordinate with designated case managers and/or medical/behavioral health care service providers;

(9) monitor progress of the members to ensure that services are received, assist in resolving identified problems, and prevent duplication of services; and

(10) be responsible for linking individuals to case management when needed if a local case manager/designated provider is not available.

[8.306.9.9 NMAC - N, 7-1-05]

8.306.9.10 COORDINATION OF PHYSICAL AND BEHAVIORAL HEALTH SERVICES BENEFITS:

A. **Coordination of physical and behavioral health services:** Physical and behavioral health services must be provided through an integrated, clinically coordinated system. Both physical and behavioral health care providers need access to relevant medical records of mutually served members to ensure maximum benefits of services to the member. Confidentiality and HIPAA laws apply during this coordination process.

B. **Coordination mechanisms:** The MCO shall implement policies and procedures designed to maximize the coordination of physical and behavioral health services and address the medical and behavioral health needs of the member.

C. **Referrals for behavioral health services:** The PCP shall identify behavioral health needs of members, and encourage and assist members in accessing behavioral health services.

D. **Referrals for physical health services:** The behavioral health provider shall encourage and assist the member in accessing needed physical health services.

E. **Referral policies and procedures:** The MCO shall develop and implement policies and procedures that encourage PCPs to refer members to behavioral health services in an appropriate and timely manner with the member's documented permission. A written report of the outcome of any referral containing sufficient information to coordinate the member's care shall be forwarded to the PCP by the behavioral health provider within 7 calendar days after screening and evaluation.

F. **Indicators for PCP referral for behavioral health services:** The following are common indicators for referral to behavioral health services by a PCP:

(1) suicidal/homicidal ideation or behavior;

(2) at-risk of hospitalization due to a behavioral health condition;

(3) trauma victims including possible abused or neglected members;

(4) 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;

(5) request by member for behavior health services;

(6) clinical status which suggests the need for behavioral health services;

(7) identified psychosocial stressors and precipitants;

(8) treatment compliance complicated by behavioral characteristics;

(9) behavioral and psychiatric factors influencing medical condition;

(10) victims or perpetrators of abuse and neglect;

(11) non-medical management of substance abuse;

(12) follow-up to medical detoxification;

(13) an initial PCP contact or routine physical examination indicates a substance abuse problem;

(14) a prenatal visit indicates substance abuse problems;

(15) positive response to questions indicates substance abuse, observation of clinical indicators or laboratory values that indicate substance abuse;

(16) a pattern of inappropriate use of medical, surgical, trauma or emergency room services that could be related to substance abuse or other behavioral health conditions; and

(17) the persistence of serious functional impairment.

G. **Referrals for medical consultation and treatment:** The MCO shall educate and assist behavioral health providers to make appropriate referrals for physical health consultation and treatment.

H. **Independent access:** The MCOs shall develop and implement policies and procedures that allow member access to behavioral health services directly and without referral from the PCP. These policies and procedures shall require timely access to behavioral health services.

I. **Behavioral health plan of care:** A behavioral health provider or the PCP will take responsibility for developing and implementing the member's behavioral health plan of care, in coordination with the member, parent and/or legal guardian and other providers when clinically indicated. With the member's documented permission, multiple behavioral health providers will coordinate their treatment plans and progress information to provide optimum care for the member. Care coordinators and case managers will be responsible for monitoring the coordination of the plan of care and information sharing for members receiving behavioral health care from multiple providers.

J. **On-going reporting:**

(1) With the member's documented permission, the behavioral health provider shall keep the member's PCP informed 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 or from behavioral health services; and

(e) transitions in level of care.

(2) With the member's documented permission, the PCP shall keep the behavioral health provider informed of the following:

(a) drug therapy;

(b) laboratory and radiology results;

(c) medical consultations; and

(d) sentinel events such as hospitalization and emergencies.

K. **Psychiatric consultation:** The PCP and other behavioral health providers are encouraged to obtain consultations and assistance with psychopharmacotherapy and diagnostic evaluations from a psychiatrist or other behavioral health specialist with prescribing authority when clinically appropriate.

[8.306.9.10 NMAC - N, 7-1-05]

HISTORY OF 8.306.9 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 10 ENCOUNTERS

8.306.10.1 ISSUING AGENCY: Human Services Department
[8.306.10.1 NMAC - N, 7-1-05]

8.306.10.2 SCOPE: This rule applies to the general public.
[8.306.10.2 NMAC - N, 7-1-05]

8.306.10.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 subject to special terms and conditions.
[8.306.10.3 NMAC - N, 7-1-05]

8.306.10.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver, and subject to availability of funds.
[8.306.10.4 NMAC - N, 7-1-05]

8.306.10.5 EFFECTIVE DATE: July 1, 2005, unless a later date is cited at the end of a section.
[8.306.10.5 NMAC - N, 7-1-05]

8.306.10.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico state coverage insurance program.
[8.306.10.6 NMAC - N, 7-1-05]

8.306.10.7 DEFINITIONS: See 8.306.1.7 NMAC.
[8.306.10.7 NMAC - N, 7-1-05]

8.306.10.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.306.10.8 NMAC - N, 7-1-05]

8.306.10.9 ENCOUNTERS: MCOs shall submit encounter data to HSD under requirements established by HSD. HSD maintains oversight responsibility for evaluating and monitoring the volume, timeliness and quality of encounter data submitted by the MCOs. If an MCO contracts with a third party to process and submit encounter data, the MCO remains responsible for the quality, accuracy and

timeliness of the encounter data submitted to HSD. HSD shall communicate directly with the MCO not with the third party contractor, regarding requirements, deficiencies, quality, accuracy and timeliness of encounter data.
[8.306.10.9 NMAC - N, 7-1-05]

8.306.10.10 ENCOUNTER SUBMISSION MEDIA: Encounter data shall be submitted to HSD or its designee on electronic media, as designated and directed by HSD.
[8.306.10.10 NMAC - N, 7-1-05]

8.306.10.11 ENCOUNTER SUBMISSION TIME FRAMES: HSD shall establish error thresholds, time frames and procedures for the submission, correction and resubmission of encounter data.
[8.306.10.11 NMAC - N, 7-1-05]

8.306.10.12 ENCOUNTER DATA ELEMENTS: Encounter data elements are based on HIPAA compliant formats developed by CMS and HSD for use in managed care. Encounter data elements are specified in the medicaid systems manual. The human services department may increase or reduce or make mandatory or optional, data elements as it deems necessary.
[8.306.10.12 NMAC - N, 7-1-05]

HISTORY OF 8.306.10 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 11 REIMBURSEMENT

8.306.11.1 ISSUING AGENCY: New Mexico Human Services Department
[8.306.11.1 NMAC - N, 7-1-05]

8.306.11.2 SCOPE: This rule applies to the general public.
[8.306.11.2 NMAC - N, 7-1-05]

8.306.11.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act, subject to special terms and conditions.
[8.306.11.3 NMAC - N, 7-1-05]

8.306.11.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver, and subject to availability of funds.
[8.306.11.4 NMAC - N, 7-1-05]

8.306.11.5 EFFECTIVE DATE: July 1, 2005, unless a later date is cited at the end of a section.
[8.306.11.5 NMAC - N, 7-1-05]

8.306.11.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico SCI program.
[8.306.11.6 NMAC - N, 7-1-05]

8.306.11.7 DEFINITIONS: See 8.306.1.7 NMAC.
[8.306.11.7 NMAC - N, 7-1-05]

8.306.11.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.306.11.8 NMAC - N, 7-1-05]

8.306.11.9 REIMBURSEMENT:

A. MCO and HSD shall comply with 8.305.11.9 NMAC, *Reimbursement for Managed Care* for the SCI program.

B. **Payment of premiums:** In addition to capitation payments from HSD, the MCO shall receive premium payments as specified by HSD. Premiums will be paid as follows:

(1) **employer premium** amount determined by department.; and

(2) **employee or individual premium** determined by department based on the federal poverty limits as follows: 0-100% per month, 101-150% per month, 151-200% per month,

C. **Premium timeframes:** Initial premiums are due to the MCO immediately upon enrollment and prior to the 1st day of the month before coverage begins. An employer group or individual member can only receive coverage when the premium has been paid. Capitation payments will not be paid unless verification of premium payment through the roster is received. If payment is not current within that timeframe, the employer group or individual member will not be covered for the next month and will not be able to enroll in an SCI MCO for a period of twelve months for an employer group or six months for an individual member.

D. **Responsibility for premium payment:** For members in an employer group, the employer shall be responsible for ensuring payment of the employer and employee share (if any) of premiums. For individuals who are not affiliated with an employer group, the individual or an entity paying on behalf of an individual shall be responsible for payment of both the employer and individual premium amount (if any). If a member who is part of an employer group has met the cost-sharing maximum, as verified by the MCO. HSD shall be responsible for payment of the member's; but not the employer's share of premiums. For individual members not in an employer group who have met the cost-sharing maximum, HSD shall be responsible for both the member's and the employer's share of premiums.
[8.306.11.9 NMAC - N, 7-1-05]

HISTORY OF 8.306.11 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 12 MEMBER GRIEVANCE RESOLUTION

8.306.12.1 ISSUING AGENCY: Human Services Department
[8.306.12.1 NMAC - N, 7-1-05]

8.306.12.2 SCOPE: This rule applies to the general public.
[8.306.12.2 NMAC - N, 7-1-05]

8.306.12.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act, subject to special terms and conditions.
[8.306.12.3 NMAC - N, 7-1-05]

8.306.12.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver, and subject to availability of funds.
[8.306.12.4 NMAC - N, 7-1-05]

8.306.12.5 EFFECTIVE DATE: July 1, 2005, unless a later date is cited at the end of a section.
[8.306.12.5 NMAC - N, 7-1-05]

8.306.12.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico SCI program.
[8.306.12.6 NMAC - N, 7-1-05]

8.306.12.7 DEFINITIONS: See 8.306.1.7 NMAC.

[8.306.12.7 NMAC - N, 7-1-05]

8.306.12.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.306.12.8 NMAC - N, 7-1-05]

8.306.12.9 GRIEVANCE SYSTEM:

A. The MCO shall have a grievance system in place for members that includes a grievance process related to dissatisfaction, and an appeals process related to an MCO action, including the opportunity to request an HSD fair hearing.

B. A grievance is a member's expression of dissatisfaction about any matter or aspect of the MCO or its operation other than an MCO action, as defined below.

C. An appeal is a request for review by the MCO of an MCO action. An action is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure to provide services in a timely manner. An untimely service authorization constitutes a denial and is thus considered an action.

D. The member, legal guardian of the member for minors or incapacitated adults, or a representative of the member as designated in writing to the MCO, has the right to file a grievance or an appeal of the MCO action on behalf of the member. A provider acting on behalf of the member and with the member's written consent may file a grievance and/or an appeal of an MCO action.

E. In addition to the MCO grievance and appeal process described above, a member, legal guardian of the member for an incapacitated adult, or the representative of the member has the right to request a fair hearing on behalf of the member with HSD directly as described in 8.352.2 NMAC, *Fair Hearings,* if an MCO decision results in termination, modification, suspension, reduction, or denial of services to the member or if the member believes the MCO has taken an action erroneously. A fair hearing may be requested only after the MCO grievance/appeal process has been exhausted. Issues of late premium payment or failure to pay the premium addressed through the MCO grievance and appeal process and not resolved at that level must next be taken to judicial appeal in the state district court at the appellant's expense.
[8.306.12.9 NMAC - N, 7-1-05]

8.306.12.10 GENERAL REQUIREMENTS FOR GRIEVANCE AND APPEALS:

A. The MCO shall implement written policies and procedures describing how the member may register a grievance or an appeal with the MCO or register a request for a fair hearing with HSD. The policy should include a description of how the MCO resolves the grievance or appeal.

B. The MCO shall provide to all service providers in the MCO's network a written description of the MCO's grievance and appeal process and how the provider can submit a grievance and/or appeal.

C. The MCO shall have available reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

D. The MCO shall name a specific individual(s) designated as the MCO's medicaid member grievance coordinator with the authority to administer the policies and procedures for resolution of a grievance and/or an appeal, to review patterns/trends in grievances and/or appeals, and to initiate corrective action.

E. The MCO shall ensure that the individuals who make decisions on grievances and/or appeals are not involved in any previous level of review or decision making. The MCO shall also ensure that health care professionals with appropriate clinical expertise will make decisions for the following:

(1) an appeal of an MCO denial that is based on lack of medical necessity;

(2) an MCO denial that is upheld in an expedited resolution;

(3) a grievance or appeal that involves clinical issues.

F. Upon enrollment, the MCO shall provide members, at no cost, with a member information sheet or handbook that provides information on how they and/or their representative(s) can file a grievance and/or an appeal, and the resolution process. The member information shall also advise members of their right to file a request for an administrative hearing with the HSD hearings bureau following an appeal of the MCO action. The information shall meet the standards for communication specified in 8.305.8.15 NMAC.

G. The MCO must ensure that punitive or retaliatory action is not taken against a member or a provider that files a grievance and/or an appeal, or a provider that supports a member's grievance and/or appeal.
[8.306.12.10 NMAC - N, 7-1-05]

8.306.12.11 GRIEVANCE: A grievance is a member's expression of dissatisfaction about any matter or aspect of the MCO or its operation other than an MCO action.

A. A member may file a grievance either orally or in writing with the MCO within 90 calendar days of the date the dissatisfaction occurred. The legal guardian of the member for incapacitated adults, a representative of the member as designated in writing to the MCO, and a 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 (5) working days of receipt of the grievance, the MCO 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 MCO resolution process for grievances shall be completed within thirty (30) calendar days of the date the grievance is received by the MCO and shall include a resolution letter to the grievant.

D. The MCO may request an extension from HSD of up to fourteen (14) calendar days if the member requests the extension, or the MCO demonstrates to HSD that there is need for additional information, and the extension is in the member's interest. For any extension not requested by the member, the MCO shall give the member written notice of the reason for the extension within two (2) working days of the decision to extend the timeframe.

E. Upon resolution of the grievance, the MCO shall mail a resolution letter to the member. The resolution letter must 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.
[8.306.12.11 NMAC - N, 7-1-05]

8.306.12.12 APPEALS: An appeal is a request for review by the MCO of an MCO action.

A. Action is defined as:

(1) the denial or limited authorization of a requested service, including the type or level of service;

(2) the reduction, suspension, or termination of a previously authorized service;

(3) the denial, in whole or in part, of payment for a service;

(4) the failure of the MCO to provide services in a timely manner, as defined by HSD; or

(5) the failure of the MCO to

complete the authorization request in a timely manner as defined in 42 CFR Section 438.408.

B. **Notice of MCO action:** The MCO shall mail a notice of action to the member and/or provider within 10 days of the date of an action except for denial of claims which may result in member financial liability which requires immediate notification. The notice must contain but not be limited to the following:

(1) the action the MCO has taken or intends to take;

(2) the reasons for the action;

(3) the member's or the provider's right to file an appeal of the MCO action through the MCO;

(4) the member's right to request an HSD fair hearing and what the process would be;

(5) the procedures for exercising the rights specified;

(6) the circumstances under which expedited resolution of an appeal is available and how to request it; and

(7) the member's right to have benefits continue pending resolution of an appeal, how to request the continuation of benefits, and the circumstances under which the member may be required to pay the costs of continuing these benefits.

C. A member may file an appeal of an MCO action within 90 calendar days of receiving the MCO's notice of action. The legal guardian of the member for incapacitated adults, a representative of the member as designated in writing to the MCO, or a provider acting on behalf of the member with the member's written consent, have the right to file an appeal of an action on behalf of the member.

D. The MCO has thirty (30) calendar days from the date the oral or written appeal is received by the MCO to resolve the appeal.

E. The MCO shall have a process in place that that assures that an oral inquiry from a member seeking to appeal an action is treated as an appeal (to establish the earliest possible filing date for the appeal). An oral appeal must be followed by a written appeal within 10 calendar days that is signed by the member. The MCO will make best efforts to assist members as needed with the written appeal.

F. Within five (5) working days of receipt of the appeal, the MCO shall provide the grievant with written notice that the appeal has been received and the expected date of its resolution. The MCO shall confirm in writing receipt of oral appeals, unless the member or the provider requests an expedited resolution.

G. The MCO has thirty (30) calendar days from the date the oral or written appeal is received by the MCO to resolve the appeal.

H. The MCO may extend the thirty 30-day timeframe by 14 calendar days if the member requests the extension, or the MCO demonstrates to HSD that there is need for additional information, and the extension is in the member's interest. For any extension not requested by the member, the MCO must give the member written notice of the extension and the reason for the extension within two (2) working days of the decision to extend the timeframe.

I. The MCO shall provide the member and/or the member's representative a reasonable opportunity to present evidence, and allegations of the fact or law, in person as well as in writing.

J. The MCO shall provide the member and/or the representative the opportunity, before and during the appeals process, to examine the member's case file, including medical or clinical records, and any other documents and records considered during the appeals process. The MCO shall include as parties to the appeal the member and his or her representative, or the legal representative of a deceased member's estate.

K. For all appeals, the MCO shall provide written notice within the thirty 30-calendar-day timeframe of the appeal resolution to the member or the provider, if the provider filed the appeal.

(1) The written notice of the appeal resolution must include, but not be limited to, the following information:

(a) the result(s) of the appeal resolution; and

(b) the date it was completed.

(2) The written notice of the appeal resolution for appeals not resolved wholly in favor of the member must include, but not be limited to, the following information:

(a) the right to request an HSD fair hearing and how to do so;

(b) the right to request receipt of benefits while the hearing is pending, and how to make the request; and

(c) that the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's action.

L. The MCO may continue benefits while the appeal and/or the HSD fair hearing process is pending.

(1) The MCO must continue the member's benefits if all of the following are met:

(a) the member or the provider files a timely appeal of the MCO action (within 10 days of the date the MCO mails the notice of action);

(b) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(c) the services were ordered by an authorized provider;

(d) the time period covered by the original authorization has not expired; and

(e) the member requests extension of the benefits.

(2) The MCO shall provide benefits until one of the following occurs:

(a) the member withdraws the appeal;

(b) ten days have passed since the date the MCO mailed the resolution letter, providing the resolution of the appeal was against the member and the member has taken no further action;

(c) HSD issues a hearing decision adverse to the member; and

(d) the time period or service limits of a previously authorized service has expired.

(3) If the final resolution of the appeal is adverse to the member, that is, the MCO's/SE's action is upheld, the MCO may recover the cost of the services furnished to the member while the appeal was pending to the extent that services were furnished solely because of the requirements of this section, and in accordance with the policy in 42 CFR Section 431.230(b).

(4) If the MCO or HSD reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

(5) If the MCO or HSD reverses a decision to deny, limit or delay services and the member received the disputed services while the appeal was pending, the MCO must pay for these services.

[8.306.12.12 NMAC - N, 7-1-05]

8.306.12.13 EXPEDITED RESOLUTION OF APPEALS: An expedited resolution of an appeal is an expedited review by the MCO of an MCO action.

A. The MCO shall establish and maintain an expedited review process for appeals when the MCO determines that taking 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 provider's support of the member's request;

(3) a provider's request on behalf of the member; or

(4) the MCO's independent determination.

B. The MCO shall ensure that the expedited review process is convenient and efficient for the member.

C. The MCO shall resolve the appeal within three (3) working days of receipt of the request for an expedited appeal, if the request meets the definition of expedited.

D. The MCO may extend the timeframe by up to 14 calendar days if the member requests the extension, or the MCO demonstrates to HSD that there is need for additional information and the extension is in the member's interest. For any extension not requested by the member, the MCO shall give the member written notice of the reason for the delay.

E. The MCO shall ensure that punitive action is not taken against a member or a provider who requests an expedited resolution or supports a member's expedited appeal.

F. The MCO shall provide expedited resolution if the request meets the definition of an expedited appeal in response to an oral or written request from the member or provider on behalf of the member.

G. The MCO shall inform the member of the limited time available to present evidence and allegations in fact or law.

H. If the MCO denies a request for an expedited resolution of an appeal, it shall:

(1) transfer the appeal to the thirty (30)-day timeframe for standard resolution, in which the 30-day period begins on the date the MCO received the request;

(2) make reasonable efforts to give the member prompt oral notice of the denial, and follow up with a written notice within two (2) calendar days; and

(3) inform the member in the written notice of the right to file an appeal and/or request an HSD fair hearing if the member is dissatisfied with the MCO's decision to deny an expedited resolution.

I. The MCO shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.
[8.306.12.13 NMAC - N, 7-1-05]

8.306.12.14 SPECIAL RULE FOR CERTAIN EXPEDITED SERVICE AUTHORIZATION DECISIONS: In the case of expedited service authorization decisions that deny or limit services, the MCO shall, within 72 hours of receipt of the request for service, automatically file an appeal on behalf of the member, make a best effort to give the member oral notice of the decision on the automatic appeal, and make a best effort to resolve the appeal.
[8.306.12.14 NMAC - N, 7-1-05]

8.306.12.15 OTHER RELATED MCO PROCESSES:

A. **Information about grievance system to providers and subcontractors:** The MCO must provide information specified in 42 CFR Section, 438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.

B. **Grievance and/or appeal files:**

(1) All grievance and/or appeal files shall be maintained in a secure and designated area and be accessible to HSD, upon request, for review. Grievance and/or appeal files shall be retained for six (6) years following the final decision by the MCO, HSD, if applicable, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later.

(2) The MCO will have procedures for assuring that files contain sufficient information to identify the grievance and/or appeal, the date it was received, the nature of the grievance and/or appeal, notice to the member of receipt of the grievance and/or appeal, all correspondence between the MCO and the member, the date the grievance and/or appeal is resolved, the resolution, and 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.
[8.306.12.15 NMAC - N, 7-1-05]

8.306.12.16 MCO PROVIDER GRIEVANCE PROCESS: The MCO shall establish and maintain written policies and procedures for the filing of provider grievances. A provider shall have the right to file a grievance with the MCO regarding utilization management decisions and/or provider payment issues. Grievances shall be resolved within 30 calendar days. A provider may not file a grievance on behalf of a member without written designation by the member as the member's representative. See 8.306.12.13 NMAC for special rules for certain expedited service authorizations.
[8.306.12.16 NMAC - N, 7-1-05]

HISTORY OF 8.306.12 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 13 FRAUD AND ABUSE

8.306.13.1 ISSUING AGENCY: Human Services Department
[8.306.13.1 NMAC - N, 7-1-05]

8.306.13.2 SCOPE: This rule applies to the general public.
[8.306.13.2 NMAC - N, 7-1-05]

8.306.13.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the SCI program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act, subject to special terms and conditions.
[8.306.13.3 NMAC - N, 7-1-05]

8.306.13.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver, and subject to availability of funds.
[8.306.13.4 NMAC - N, 7-1-05]

8.306.13.5 EFFECTIVE DATE: July 1, 2005, unless a later date is cited at the end of a section.
[8.306.13.5 NMAC - N, 7-1-05]

8.306.13.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico SCI program.
[8.306.13.6 NMAC - N, 7-1-05]

8.306.13.7 DEFINITIONS: See 8.306.1.7 NMAC.
[8.306.13.7 NMAC - N, 7-1-05]

8.306.13.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.306.13.8 NMAC - N, 7-1-05]

8.306.13.9 FRAUD AND ABUSE: HSD is committed to the development and implementation of an aggressive prevention, detection, monitoring and investigation program to reduce provider/client fraud and abuse and client 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 including SCI. The MCO shall comply with provisions of state and federal fraud and abuse laws and regulations.
[8.306.13.9 NMAC - N, 7-1-05]

8.306.13.10 MANAGED CARE ORGANIZATION REQUIREMENTS: The MCO shall have in place internal controls and policies and procedures that are capable of preventing, detecting, investigating and reporting potential fraud and abuse activities concerning both providers and/or members. The MCO specific internal controls and policies and procedures shall be described in a comprehensive written plan submitted to HSD or its designee for

approval. Substantive amendments or modifications to the policies and procedures shall be approved by HSD, or its designee. At a minimum, the written plan shall include:

A. internal procedures that facilitate preliminary investigating and reporting of potential and actual fraud and abuse to HSD or its designee for further investigation;

B. a description of the specific controls in place for prevention and detection of potential cases of fraud and abuse such as: claims edits, post processing review of claims, provider profiling and credentialing; prior authorizations, utilization /quality management monitoring;

C. a mechanism to work with HSD or its designee to further develop prevention and detection mechanisms and best practices and to monitor outcomes for SCI;

D. internal procedures to prevent, detect and investigate program violations to help recover funds misspent due to fraudulent actions; and

E. the requirements to report to HSD the names of all providers identified with aberrant utilization according to provider profiles, regardless of the cause of aberrancy.

[8.306.13.10 NMAC - N, 7-1-05]

HISTORY OF 8.306.13 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 14 REPORTING REQUIREMENTS

8.306.14.1 ISSUING AGENCY: Human Services Department
[8.306.14.1 NMAC - N, 7-1-05]

8.306.14.2 SCOPE: This rule applies to the general public.
[8.306.14.2 NMAC - N, 7-1-05]

8.306.14.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the SCI program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act, subject to special terms and conditions.
[8.306.14.3 NMAC - N, 7-1-05]

8.306.14.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver, and subject to availability of funds.
[8.306.14.4 NMAC - N, 7-1-05]

8.306.14.5 EFFECTIVE DATE: July 1, 2005, unless a later date is cited at the end of a section.
[8.306.14.5 NMAC - N, 7-1-05]

8.306.14.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico SCI program.
[8.306.14.6 NMAC - N, 7-1-05]

8.306.14.7 DEFINITIONS: See 8.306.1.7 NMAC.
[8.306.14.7 NMAC - N, 7-1-05]

8.306.14.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.306.14.8 NMAC - N, 7-1-05]

8.306.14.9 REPORTING REQUIREMENTS: The contracted MCO shall comply with substantially all sections of 8.305.14 NMAC.
[8.306.14.9 NMAC - N, 7-1-05]

8.306.14.10 STATE COVERAGE INSURANCE (SCI) SPECIFIC REPORTING: The contracted MCO shall report specified information to SCI/HSD staff. These reports shall include, but not be limited to, year to date benefits for any member who:

A. reaches certain benefit thresholds;

B. has reached the maximum for any benefit; or

C. who has disenrolled from the MCO.

[8.306.14.10 NMAC - N, 7-1-05]

HISTORY OF 8.306.14 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 15 SERVICES FOR SCI MEMBERS WITH SPECIAL HEALTH CARE NEEDS

8.306.15.1 ISSUING AGENCY: Human Services Department
[8.306.15.1 NMAC - N, 7-1-05]

8.306.15.2 SCOPE: This rule applies to the general public.
[8.306.15.2 NMAC - N, 7-1-05]

8.306.15.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act, subject to special terms and conditions.
[8.306.15.3 NMAC - N, 7-1-05]

8.306.15.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver, and subject to availability of funds.
[8.306.15.4 NMAC - N, 7-1-05]

8.306.15.5 EFFECTIVE DATE: July 1, 2005, unless a later date is cited at the end of a section.
[8.306.15.5 NMAC - N, 7-1-05]

8.306.15.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico SCI program.
[8.306.15.6 NMAC - N, 7-1-05]

8.306.15.7 DEFINITIONS: See 8.306.1.7 NMAC.
[8.306.15.7 NMAC - N, 7-1-05]

8.306.15.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.306.15.8 NMAC - N, 7-1-05]

8.306.15.9 SERVICES FOR SCI MEMBERS WITH SPECIAL HEALTH CARE NEEDS (SCI-SHCN):

A. SCI-SHCN require a broad range of primary, specialized medical, behavioral health and related services. SCI-SHCN are individuals who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition, or low to severe functional limitation and who also require health and related services of a type or amount beyond that required by individuals. SCI-SHCN have ongoing health conditions, high or complex service utilization, and low to severe functional limitations. The primary purpose of the definition is to identify these individuals so that the MCO can facilitate access to appropriate services. The definition also allows for flexible targeting of individuals based on clinical justification and discontinuing targeted efforts when such efforts are no longer needed.

B. **Identification of enrolled SCI-SHCN:** The MCO shall have written policies and procedures in place

with HSD approval, which govern how members with multiple and complex physical and behavioral health care needs shall be identified. The MCOs shall have an internal operational process, in accordance with policy and procedure, to target members for the purpose of applying stratification criteria to identify SCI-SHCNs. The MCO shall employ reasonable effort to identify SCI-SHCNs based at least on the following criteria:

(1) individuals eligible for SSI;

(2) individuals identified by service utilization, clinical assessment, or diagnosis; and

(3) referral by family or a public or community program

[8.306.15.9 NMAC - N, 7-1-05]

8.306.15.10 SCI ENROLLMENT FOR SCI-SHCN:

A. **Switch enrollment:** Individual members (not enrolled in an employer group), including SCI-SHCN, may request to break a lock-in and be switched to membership in another MCO, based on cause. The member, the member's family or legal guardian shall contact HSD to request that the member be switched to another MCO. The MCO shall have policies and procedures to facilitate a smooth transition of a member who switches enrollment to another MCO. See Subsection E of 8.306.5.9 NMAC, *Member Switch Enrollment*.

B. **SCI-SHCN information and education:**

(1) The MCO shall develop and distribute to SCI-SHCN members, caregivers, parents and/or legal guardians, as appropriate, information and materials specific to the needs of this population. This includes information, such as items and services that are provided or not provided by the SCI program, information about how to arrange transportation, and which services require a referral from the PCP. The individual, family, caregiver, or legal guardian shall be informed on how to present an individual for care in an emergency room that is unfamiliar with the individual's special health care needs and about the availability of care coordination. See 8.306.9 NMAC, *Coordination Of Benefits*. This information may be included either in a special member handbook or in a SCI-SHCN insert to the MCO member handbook.

(2) The MCO shall provide health education information to assist a SCI-SCHN and/or caregivers in understanding how to cope with the day-to-day stress caused by chronic illness, including chronic behavioral health conditions.

(3) The MCO shall provide SCI-SHCNs and/or caregivers a list of key MCO resource people and their telephone numbers. The MCO shall designate a single point of contact that a SCI-SHCN, family member, caregiver, or provider may call for information.

[8.306.15.10 NMAC - N, 7-1-05]

8.306.15.11 CHOICE OF SPECIALIST AS PCP: The MCO shall develop and implement policies and procedures governing the process for member selection of a PCP, including the right by an SCI-SHCN to choose a specialist as a PCP, including a psychiatrist in the case of behavioral health. The specialist provider must agree to be the PCP.

[8.306.15.11 NMAC - N, 7-1-05]

8.306.15.12 SPECIALTY PROVIDERS FOR (SCI-SHCN): The MCO shall have policies and procedures in place to allow direct access to necessary specialty care, consistent with SCI access appointment standards for clinical urgency, including behavioral health access standards. See 8.306.8 NMAC.

[8.306.15.12 NMAC - N, 7-1-05]

8.306.15.13 CARE COORDINATION FOR SCI-SHCN: The MCOs shall develop policies and procedures to provide care coordination for SCI-SHCN. Please refer to 8.306.9 NMAC, *Coordination Of Benefits*, for definition.

A. The MCO shall have an internal operational process, in accordance with policy and procedure, to target medicaid members for purposes of applying stratification criteria to identify those who are potential SCI-SHCN. The contractor will provide HSD with the applicable policy and procedure describing the targeting and stratification process.

B. The MCO shall have written policies and procedures to ensure that each member identified as having special health care needs is assessed by an appropriate health care professional regarding the need for care coordination. If the member has both physical and behavioral health special needs, the MCO and SE shall coordinate care in a timely collaborative manner.

C. The MCO shall have written policies and procedures for educating SCI-SHCN needs. [8.306.15.13 NMAC - N, 7-1-05]

8.306.15.14 EMERGENCY, INPATIENT AND OUTPATIENT AMBULATORY SURGERY HOSPITAL REQUIREMENTS FOR SCI-SHCN: The MCO shall develop and implement policies and procedures for:

A. educating SCI-SHCN, SCI-SHCN's family members and/or caregivers with complicated clinical histories on how to access emergency room care and what clinical history to provide when emergency care or inpatient admission is needed, including behavioral health emergency care;

B. how coordination with the PCP, the SE (if applicable) and the hospitalist shall occur when an SCI-SHCN is hospitalized;

C. ensuring that the emergency room physician has access to the individual's medical and/or behavioral health clinical history; and

D. obtaining any necessary referrals from PCPs for inpatient hospital staff providing outpatient or ambulatory surgical procedures.

[8.306.15.14 NMAC - N, 7-1-05]

8.306.15.15 REHABILITATION THERAPY SERVICES (PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY) FOR SCI-SHCN: The MCO shall:

A. develop and implement therapy using clinical practice guidelines specific to acute, chronic or long-term conditions of their SCI-SHCN that meet medical necessity criteria and are based on HSD's adult rehabilitation services policy in compliance with SCI benefits;

B. involve the SCI-SHCN's family, caregivers, physicians and therapy providers in identifying issues to be included in the plan of care; and

C. develop and implement utilization prior approval and continued stay criteria, including time frames, that are appropriate to the chronicity of the member's status and anticipated development process.

[8.306.15.15 NMAC - N, 7-1-05]

8.306.15.16 DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES FOR SCI-SHCN: The MCO shall in compliance with available benefits for SCI:

A. develop and implement a process to permit members utilizing supplies on an ongoing basis to submit a list of supplies to the DME provider on a monthly basis; the 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 provider is out of compliance; and

C. have an emergency response plan for DME and medical supplies needed on an emergency basis.

[8.306.15.16 NMAC - N, 7-1-05]

8.306.15.17 CLINICAL PRACTICE GUIDELINES FOR PROVISION

OF CARE TO SCI-SHCN: The MCO shall develop clinical practice guidelines, practice parameters and other criteria that consider the needs of SCI-SHCN 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.
[8.306.15.17 NMAC - N, 7-1-05]

8.306.15.18 UTILIZATION MANAGEMENT (UM) FOR SERVICES TO SCI-SHCN: The MCO shall develop written policies and procedures to exclude from prior authorization any item of service identified in the course of treatment and documented in the treatment plan, and/or extend the authorization period for services provided for chronic conditions. There shall be a process for review and periodic update for the course of treatment, as indicated.
[8.306.15.18 NMAC - N, 7-1-05]

8.306.15.19 ADDITIONS TO CONSUMER ASSESSMENT OF HEALTH PLANS SURVEY (CAHPS) FOR (SCI-SHCN): The MCO shall add questions about SCI-SHCN to the most current HEDIS CAHPS survey.
[8.306.15.19 NMAC - N, 7-1-05]

8.306.15.20 SCI-SHCN PERFORMANCE MEASURES: The MCO shall initiate a performance measure specific to SCI-SHCN. See 8.306.8 NMAC, *Quality Management*.
[8.306.15.20 NMAC - N, 7-1-05]

HISTORY OF 8.306.15 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 16 CLIENT TRANSITION OF CARE

8.306.16.1 ISSUING AGENCY: Human Services Department
[8.306.16.1 NMAC - N, 7-1-05]

8.306.16.2 SCOPE: This rule applies to the general public.
[8.306.16.2 NMAC - N, 7-1-05]

8.306.16.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act, subject to special terms and conditions.
[8.306.16.3 NMAC - N, 7-1-05]

8.306.16.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver, and subject to availability of funds.
[8.306.16.4 NMAC - N, 7-1-05]

8.306.16.5 EFFECTIVE DATE: July 1, 2005, unless a later date is cited at the end of a section.
[8.306.16.5 NMAC - N, 7-1-05]

8.306.16.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico SCI program.
[8.306.16.6 NMAC - N, 7-1-05]

8.306.16.7 DEFINITIONS: See 8.306.1.7 NMAC.
[8.306.16.7 NMAC - N, 7-1-05]

8.306.16.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.306.16.8 NMAC - N, 7-1-05]

8.306.16.9 CLIENT TRANSITION OF CARE: The MCO shall actively assist with transition of care issues. During the individual member's SCI recertification of eligibility period and re-enrollment, the member may switch enrollment to a different MCO. Employer groups may also switch MCOs during the group re-enrollment process. Certain members may lose their SCI eligibility while enrolled in an MCO. A member changing from one MCO to another SCI MCO shall continue to receive medically necessary services in an uninterrupted manner. The MCO shall have the resources and policies and procedures in place to ensure continuity of care without disruption in service to members and to assure the service provider of payment.

A. **Member transition:** The MCO shall have policies and procedures that address member identification and the clinical transition and transfer of members into or out of the MCO.

(1) The MCO shall have policies and procedures that cover potentially large or mass transfer of members into or out of the MCO, including the identification of members currently receiving services.

(2) The MCO shall have policies and procedures covering the transition into the MCO of an individual member, which shall include member education about the MCO and the review and update of existing treatment plans.

(3) The MCO shall have policies and procedures that identify members transferring out of the MCO and ensure the provision of member data and clinical information to the future MCO necessary to avoid delays in member treatment.

B. **Special payment requirement.** The MCO shall be responsible for payment of covered medical services, provided to the member for any month the MCO receives a capitation payment, even if the member has lost SCI eligibility.

C. Tracking of members who are nearing the annual claims benefit maximum or annual bed-day maximum.

(1) MCOs will track dollars paid for claims and hospital inpatient days (including home care days) for each SCI member and identify individuals who are at 85% of claims benefits paid out in a benefit year and those who have utilized 80% of their available hospital inpatient resources.

(2) Identified members who are at the 85% level of claims payments or at 80% of hospital days available will have all care coordinated by the MCO to identify methods to manage care so as to best utilize the remaining dollars and days to maximize care and prevent member from reaching benefit claims and/or hospital day maximum.

(3) MCO will provide information on these individuals to HSD who will work in conjunction with the MCO to find alternative health care options for these individuals.

D. **Claims processing and payment:** In the event that an MCO's contract with HSD has ended, is not renewed or is terminated, the CONTRACTOR shall remain responsible for processing and paying claims for services delivered through the contract period, but submitted after the MCO's contract has ended.

(1) The MCO shall be required to inform providers in writing, at least 30 days prior to the end of the contract, of the termination of the contract and of the process for providers to submit claims for services provided through the contract end date. The letter shall include the telephone, fax numbers, and the billing address for claims submissions as well as the names of persons to contact with questions.

(2) The MCO shall allow six months to process claims for services provided prior to the contract termination date.

(3) The MCO shall continue to meet timeframes established for processing all claims.
[8.306.16.9 NMAC - N, 7-1-05]

HISTORY OF 8.306.16 NMAC: [RESERVED]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.200.400 NMAC, Section 10, which will be effective on July 1, 2005. The Medical Assistance Division amended the section to add a Subsection O to include State Coverage Insurance (SCI) as an eligibility category.

8.200.400.10 BASIS FOR DEFINING GROUP: Individuals are eligible for medicaid if they meet the specific criteria for one of the eligibility categories. In New Mexico, other medical assistance programs for individuals who do not qualify for medicaid are available, such as the children's medical services program (category 007) administered by the New Mexico department of health.

A. **Assistance groups:** The HSD income support division (ISD) determines eligibility for individuals applying for medicaid.

(1) Category 002 provides medicaid for families with dependent child(ren) for individuals who meet July 16, 1996 AFDC related eligibility criteria.

(2) Category 027 provides four (4) months of medicaid if category 002 medicaid eligibility is lost due to increased child support.

(3) Transitional medicaid (category 028) extends medicaid benefits up to twelve (12) months for families who lose category 002 medicaid eligibility due to increased earnings or loss of the earned income disregard.

(4) Category 033 provides medicaid for individuals who are ineligible for category 002 medicaid due to income or resources deemed from a stepparent, grandparent, or sibling.

B. **Medical assistance for women and children:** ISD offices establish eligibility for medical assistance for women and children (MAWC) categories. For these categories, medicaid coverage does not depend on one or both parents being dead, absent, disabled, or unemployed. Children and pregnant women in intact families may be eligible for these Medicaid categories.

(1) **Category 030:** This category provides the full range of medicaid coverage for pregnant women in families meeting AFDC income and resource standards.

(2) **Category 031:** This category provides twelve (12) months of medicaid coverage for babies born to mothers who, at the time of the birth, were either eligible for and receiving New Mexico medicaid or were deemed to have been eligible for and receiving New Mexico medicaid. To receive the full twelve (12) months of coverage, all of the following criteria must be met:

(a) The mother remains eligible for New Mexico medicaid (or would be eligible if she were still pregnant).

(b) The baby remains with the mother.

(c) Both mother and baby continue to reside in New Mexico.

(3) **Category 032:** This category provides medicaid coverage to children who are under 19 years of age in families with incomes under 235% of federal income poverty guidelines. Uninsured children in families with income between 185-235% of FPL are eligible for the state children's health insurance program (SCHIP). Certain additional eligibility criteria are applicable under SCHIP, as well as co-payment requirements. Native American children are exempt from co-payments.

(4) **Category 035:** This category provides medicaid coverage for pregnancy-related services for pregnant women and family planning services for women in families whose income is below 185% of the federal income poverty level. There is no resource test for this category.

C. **Supplemental security income:** Eligibility for supplemental security income (SSI) is determined by the social security administration. This program provides cash assistance and medicaid for eligible aged (category 001), blind (category 003) or disabled (category 004) recipients. ISD offices determine medicaid eligibility for individuals who are ineligible for SSI due to income or resources deemed from stepparents (category 034).

D. **Medicaid extension:** Medicaid extension provides medicaid coverage for individuals who lose eligibility for SSI due to a cost of living increase in social security benefits and to individuals who lose SSI for other specific reasons. Under the "Pickle Amendment" to the Social Security Act, medicaid coverage is extended to individuals who lose SSI for any reason which no longer exists and who meet SSI eligibility criteria when social security cost-of-living increases are disregarded.

(1) Individuals who meet the following requirements may also be eligible for medicaid extension:

(a) widow(er)s between sixty (60) and sixty-four (64) years of age who lose SSI eligibility due to receipt of or increase in early widow(er)s' Title II benefits; eligibility ends when an individual becomes eligible for part A medicare or reaches age sixty-five (65);

(b) certain disabled adult children (DACs) who lose SSI eligibility due to receipt of or increase in Title II DAC benefits;

(c) certain disabled widow(er)s and disabled surviving divorced spouses who lose SSI eligibility due to receipt of or increase in disabled widow(er)s or disabled surviving divorced spouse's Title II benefit; medicaid eligibility ends when individuals become eligible for part A medicare;

(d) non-institutionalized individuals who lose SSI eligibility because the amount of their initial Title II benefits exactly equals the income ceiling for the SSI program; and

(e) certain individuals who become ineligible for SSI cash benefits and, therefore, medicaid as well, may receive up to two (2) months of extended medicaid benefits while they apply for another category of medicaid.

(2) Medicaid extension categories include individuals who are sixty-five (65) years and older (category 001), individuals who are less than sixty-five (65) years of age and blind (category 003) and individuals who are less than sixty-five (65) years of age and disabled (category 004).

E. **Institutional care medicaid:** ISD offices establish eligibility for institutional care medicaid. Individuals who are aged (category 081), blind (category 083) or disabled (category 084) must require institutional care in nursing facilities (NFs), intermediate care facilities for the mentally retarded (ICF-MRs), or acute care hospitals and meet all SSI eligibility criteria, except income, to be eligible for these medicaid categories.

F. **Home and community-based waiver services:** ISD offices establish the financial eligibility for individuals who apply for medicaid under one of the home and community based waiver programs. Individuals must meet the resource, income, and level of care standards for institutional care; however, these individuals receive services at home. The waiver programs are listed below:

(1) Acquired immunodeficiency syndrome (AIDS) and AIDS-related condition (ARC) waiver. (category 090).

(2) Disabled and elderly waiver - aged (category 091), blind (category 093), disabled (category 094).

(3) Medically fragile waiver (category 095).

(4) Developmental disabilities waiver (category 096).

G. **Qualified medicare beneficiaries:** Medicaid covers the payment of medicare premiums as well as deductible and coinsurance amounts for medicare-covered services under the qualified medicare beneficiaries (QMB) program for individuals who meet certain income and resource standards (category 040). To be eligible, an individual must have or be conditionally eligible for medicare hospital insurance (medicare part A).

H. **Qualified disabled working individuals:** Medicaid covers the

payment of part A medicare premiums under the qualified disabled working individuals (QDs) program for individuals who lose entitlement to free part A medicare due to gainful employment (category 042). To be eligible, individuals must meet the social security administration's definition of disability and be enrolled for premium part A. These individuals must also meet certain income and resource standards. They are not entitled to additional medicaid benefits and do not receive medicaid cards.

I. **Specified low-income medicare beneficiaries:** Medicaid covers the payment of medicare part B premiums under the specified low-income medicare beneficiaries (SLIMB) program for individuals who meet certain income and resource standards (category 945). To be eligible, individuals must already have medicare part A. They are not entitled to additional medicaid benefits and do not receive medicaid cards.

J. **Medical assistance for refugees:** Low-income refugees may be eligible for medical and cash assistance. Eligibility for refugee assistance programs is determined by the ISD offices. To be eligible for cash assistance and medical coverage (category 019) or medical coverage only (category 049), a refugee must meet the income criteria for AFDC programs. Refugee medical assistance is limited to an eight (8) month period starting with the month a refugee enters the United States. Refugee medical assistance is approved only in the following instances:

(1) refugees meet the AFDC standard of need when the earned income disregard is applied;

(2) refugees meet all criteria for refugee cash assistance but wish to receive only refugee [~~medial~~] medical assistance;

(3) refugees receive a four (4) month refugee medical assistance extension when eligibility for refugee cash assistance is lost due to earned income; or

(4) refugee spends-down to the AFDC standard of need (category 059).

K. **Emergency medical services for aliens:** Medicaid covers emergency services for certain nonqualified, illegal undocumented, or non-immigrant aliens who meet all eligibility criteria for one of the existing medicaid categories, except for citizenship or legal alien status. These individuals must receive emergency services from a medicaid provider and then go to an ISD office for an evaluation of medicaid eligibility. Once an eligibility determination is made, the alien must notify the servicing provider so that the claim can be submitted to MAD or its designee for a medical necessity evaluation and claim payment.

L. **Children, youth, and families medicaid:** Medicaid covers children in state foster care programs (category 006, category 046, category 066, category 086) and in adoption subsidy situations (category 017, category 037, and category 047) when the child's income is below the AFDC need standard for one person. Medicaid also covers children who are the full or partial responsibility of the children, youth, and families department (CYFD) such as category 060 and category 061). The eligibility determination for these categories is made by CYFD.

M. **Working disabled individuals:** The working disabled individuals (WDI) program (category 043) covers disabled individuals who are either employed, or who lost eligibility for supplemental security income (SSI) and medicaid due to the initial receipt of social security disability insurance (SSDI) and who do not yet qualify for medicare.

N. **Breast and cervical cancer:** The breast and cervical cancer (BCC) program (category 052) covers uninsured women, under the age of 65 who have been screened and diagnosed as having breast or cervical cancer, including pre-cancerous conditions by a contracted provider for the centers for disease control and prevention's national breast and cervical cancer early detection program (NBCCEDP)

O. **State coverage insurance:** The state coverage insurance (SCI) program (category 062) covers uninsured adults ages 19-64 who: have no other health insurance and are not eligible for other government insurance programs; have income levels up to 200% of the federal poverty limit (FPL); comply with income and eligibility requirements as specified in 8.262.400 NMAC, 8.262.500 NMAC and 8.262.600 NMAC; are employed by an employer who purchases an SCI employer group policy or who participate in an individual policy.

[2-1-95; 1-1-97; 4-1-98; 6-30-98; 3-1-99; 8.200.400.10 NMAC - Rn, 8 NMAC 4.MAD.402 & A, 7-1-01; A, 7-1-02; A, 10-1-02; A, 7-1-05]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.200.430 NMAC, Section 16, that will be effective on July 1, 2005. The Medical Assistance Division amended the section to define the co-payment responsibility for State Coverage Insurance (SCI) recipients and the section was also renumbered.

8.200.430.16 RECIPIENT FINANCIAL RESPONSIBILITIES: Providers who participate in medicaid agree to accept the amount paid as payment in full, see 42 CRF 447.15, with the exception of co-payment amounts required in certain medicaid categories. Other than the co-payments, a provider cannot bill a recipient for any unpaid portion of the bill or for a claim that is not paid because of provider administrative error or failure of multiple providers to communicate eligibility information. Native Americans are exempt from co-payment requirements.

[~~A. Direct recipient responsibility for payment~~]

[~~(1)~~] A. **Failure to follow managed care policies:** A recipient must be aware of the physicians, pharmacies, hospitals, and another provider who participate in their health maintenance organization (HMO) or other managed care plan. A recipient is responsible for payment for services if he/she uses a provider who is not a participant in his/her plan or if he/she receives any services without complying with the rules, policies, and procedures of the plan.

[~~(2)~~] B. **Denied emergency room claims:** A recipient is responsible for payment of a hospital outpatient emergency room claims if a determination is made by MAD or its designee that an emergency did not exist at the time the service was furnished.

[~~(a)~~] (1) A provider can bill the recipient directly for the denied emergency room charge.

[~~(b)~~] (2) The recipient cannot be billed for denied ancillary services, such as laboratory and radiology services.

[~~(3)~~] C. **Other recipient payment responsibilities:** If all the following conditions are met before a service is furnished, a recipient can be billed directly by a provider for services and is liable for payment:

[~~(a)~~] (1) the recipient is advised by a provider that the particular services is not covered by medicaid or are advised by a provider that he/she is not a medicaid provider;

[~~(b)~~] (2) the recipient is informed by a provider of the necessity, options, and charges for the services and the option of going to other provider who is a medicaid provider; and

[~~(c)~~] (3) the recipient agrees in writing to have the service provided with full knowledge that he/she is financially responsible for the payment.

[~~(4)~~] D. **Co-payment responsibility for SCHIP and WDI recipients:** It is the recipient's responsibility to pay the co-payment to the provider. Children eligible for category 032 with family income between 185-235% of poverty (SCHIP) and working disabled individuals (WDI), category 043, will have co-payment requirements as follows:

[~~(a)~~] (1) WDI

[~~(i)~~] (a) $7 per outpatient physician visit, other practitioner visit, clinic visit, urgent care visit, outpatient therapy

session, or behavioral health session;

[~~(ii)~~] (b) $7 per dental visit;

[~~(iii)~~] (c) $20 per emergency room visit;

[~~(iv)~~] (d) $30 per inpatient hospital admission;

[~~(v)~~] (e) $5 per prescription, applies to prescription and non-prescription drug items.

[~~(b)~~] (2) SCHIP

[~~(i)~~] (a) $5 per outpatient physician visit, other practitioner visit, clinic visit, urgent care visit, outpatient therapy session, or behavioral health session;

[~~(ii)~~] (b) $5 per dental visit;

[~~(iii)~~] (c) $15 per emergency room visit;

[~~(iv)~~] (d) $25 per inpatient hospital admission;

[~~(v)~~] (e) $2 per prescription, applies to prescription and non-prescription drug items.

[~~(5)~~] E. **Co-payment exclusions:** Certain services and populations are exempt from co-payment responsibilities.

[~~(a)~~] (1) Preventive, prenatal care services and contraceptive management services are exempt from the copayment requirement.

[~~(b)~~] (2) Services provided at Indian health service facilities, by urban Indian providers and by tribal 638s are also exempt from the co-payment requirement.

[~~(c)~~] (3) There is no co-payment required during presumptive eligibility or retroactive eligibility periods.

[~~(d)~~] (4) There is no co-payment required for services provided to Native Americans.

[~~(6)~~] F. **Co-payment maximum for SCHIP and WDI:** It is the responsibility of the family to track and total the co-payments paid. Once the family yearly maximum amount for SCHIP and WDI recipients has been paid by the family via co-payments on medicaid covered services, the recipient must notify the medical assistance division. Verification must be provided to the medical assistance division that the co-payment maximum for SCHIP and WDI recipients has been paid. The first month that co-payments will no longer be required by the SCHIP and WDI recipient is the month following the month in which it has been verified by the medical assistance division that the maximum amount has been met. If the determination is made after the twenty-fifth (25th) of the month, the change is made effective the second month after the request. No retroactive eligibility for the "met co-payment maximum" criteria is allowed. Subsequent to establishing that the co-payment maximum amount has been met, the WDI recipient and the family of SCHIP recipients is not responsible for payment of co-payments for the remainder of that calendar year.

[~~(a)~~] (1) Co-payment maximum amounts for SCHIP recipients are calculated at initial determination and re-determination of eligibility by ISD. The co-payment maximum amount calculated at the re-determination is effective for the following year.

[~~(b)~~] (2) If the family income decreases to below 185% of federal income poverty guidelines, the family may report that change and have the children changed to category 032 eligibility up to 185% of poverty, with no co-payment requirements. The change is effective in the month following the month of such determination. If the determination is made after the twenty-fifth (25th) of the month, the effective date of the change is the second month after such verification.

[~~(c)~~] (3) The family maximum co-payment amounts for SCHIP recipients are as follows:

[~~(i)~~] (a) families with income between 185-200% FPL- maximum is 3%

[~~(ii)~~] (b) families with income between 201-215% FPL- maximum is 4%

[~~(iii)~~] (c) families with income between 216-235% FPL- maximum is 5%

[~~(d)~~] (4) The co-payment maximum varies depending on the recipient's earned and unearned income. Once the recipient has reached his/her co-payment maximum on covered medicaid services, co-payments cease for the rest of that calendar year, only after the recipient has fulfilled the required steps. For SCHIP, see Paragraph (5) of Subsection A of Section 16 of 8.200.430 NMAC; for WDI, see Section 9 of 8.243.600 NMAC.

[~~(e)~~] (5) Co-payment maximum amounts for WDI recipients are calculated at initial determination, based on the income received the first month of eligibility, and every twelve months thereafter. The co-payment maximum amount calculated at the initial determination is prorated for the rest of the calendar year and is also determined for the following calendar year. At each annual periodic review, the co-payment maximum will be calculated for the following calendar year.

[~~(i)~~] (a) Recipients with earned and unearned income below 100% FPL - maximum is $600.

[~~(ii)~~] (b) Recipients with earned and unearned income between 100-250% FPL - maximum is $1500.

G. **Co-payment responsibility for state coverage insurance (SCI) recipients:** It is the recipient's responsibility to pay the co-payment to the provider. Adults eligible for category 062 with family income from 0-200% of federal poverty limit will have co-payment responsibility as follows:

Service	Co-pay at 0% - 100% FPL- 062A	Co-pay at 101% - 150% FPL-062B	Co-pay at 151% - 200% FPL-062C
Physician/provider visits (no co - pay for preventive services -see below)	$0	$5	$7
Pre/post natal care	$0	$0	$0
Preventive services	$0	$0	$0
Hospital inpatient medical/surgical	$0/day	$25/day	$30/day
Hospital inpatient maternity	$0/day	$25/day	$30/day
Hospital outpatient surgery/procedures	$0	$5	$7
Home health	$0	$5	$7
PT, OT & SLP	$0	$5	$7
Diagnostics (excluding routine lab and x-ray)	$0 (included in office visit)	$0 (included in office visit)	$0 (included in office visit)
DME/supplies	$0	$5	$7
Mental health/substance abuse outpatient	$0	$5	$7
Mental health/substance abuse inpatient	$0	$25	$30
Substance abuse intensive outpatient	$0	$5	$7
Emergency services	$0	$15 per visit, waived if admitted to a hospital within 24 hours	$20 per visit, waived if admitted to a hospital within 24 hours
Urgent care	$0	$5	$7
Prescription drugs: generic name brand	$3 per prescription	$3 per prescription	$3 per prescription
Behavioral health and substance abuse: outpatient office visit and outpatient substance abuse treatment inpatient behavioral health and inpatient detox	$0 $0	$5 $25	$7 $30
Limits on out-of-pocket expenses	Out of pocket charges for all partici pants will be limited to 5% of maximum gross family income per benefit year. Pharmacy out-of-pocket charges for all participants will be limited to $12 per month.		

H. **Co-payment exclusions for SCI recipients:** Certain services and populations are exempt from co-payment responsibilities.

(1) Prenatal care services are exempt from the co-payment requirement.

(2) Services provided at Indian health service facilities, by urban Indian providers and by tribal 638s are also exempt from the co-payment requirement.

I. **Co-payment maximum for SCI recipients:** It is the responsibility of the client to track and total the co-payments and premiums paid. Once the yearly maximum amount for SCI recipients has been paid by the individual via co-payments and premiums on covered services, the recipient must notify the managed care organization (MCO) in which he or she is enrolled. Verification must be provided to the MCO that the cost-sharing maximum for SCI has been paid. The first month that cost-sharing will no longer be required by the SCI recipient is the month following the month in which it has been verified by the MCO that the maximum amount has been met. If the determination is made after the twenty-fourth (24th) of the month, the change is made effective the second month after verification. No retroactive eligibility for the "met cost-sharing maximum" criteria is allowed. Subsequent to establishing that the cost-sharing maximum amount has been met, the SCI recipient is not responsible for payment of co-payments and premiums for the remainder of that benefit year. Co-payment maximum amounts for SCI recipients are calculated at initial determination and re-determination of eligibility by ISD at 5% of the annual countable income. The co-payment maximum amount calculated at the re-determination is effective for the following benefit year. See also 8.262.600.9 NMAC.

[2-1-95, 3-1-99, 7-1-00; 8.200.430.16 NMAC - Rn, 8 NMAC 4.MAD.437 & A, 1-1-01; A, 1-1-02; A, 6-1-04; A, 6-15-04; A, 7-1-05]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.200.510 NMAC, Section 12, which will be effective on July 1, 2005. The Medical Assistance Division amend-

ed the subsections by changing the deduction amounts.

8.200.510.12 POST-ELIGIBILITY CALCULATION (MEDICAL CARE CREDIT): Apply applicable deductions in the order listed below when determining the medical care credit for an institutionalized spouse.

DEDUCTION	AMOUNT
A. Personal needs allowance for institutionalized spouse	[~~$52~~] $54
B. Basic community spouse monthly income allowance standard (CSMIA)	[~~$1,562~~] $1,604
(CSMIA standard minus income of community spouse = deduction	
C. * Excess shelter allowance for allowable expenses for community spouse	[~~$816~~] $774
D. ** Extra maintenance allowance	
E. Dependent family member 1/3 X (CSMIA - dependent member's income)	
F. Non-covered medical expenses	
G. * The allowable shelter expenses of the community spouse must exceed for any deduction to apply.	[~~$469~~] $482 per month
H. ** To be deducted, the extra maintenance allowance for the community spouse must be ordered by a court of jurisdiction or a state administrative hearing officer.	

I. **MAXIMUM TOTAL:** The maximum total of the community spouse monthly income allowance and excess shelter deduction is [~~$2,319~~] $2,378.

[1-1-95, 7-1-95, 3-30-96, 8-31-96, 4-1-97, 6-30-97, 4-30-98, 6-30-98, 1-1-99, 7-1-99, 7-1-00; 8.200.510.12 NMAC - Rn, 8 NMAC 4.MAD.510.2 & A, 1-1-01, 7-1-01; A, 1-1-02; A, 7-1-02; A, 1-1-03; A, 7-1-03; A, 1-1-04; A, 7-1-04; A, 1-1-05; A, 7-1-05]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.1 NMAC, Section 7, which will be effective on July 1, 2005. The Medical Assistance Division amended the section for the purpose of incorporating definitions related to the transitioning of the delivery of Medicaid behavioral health services from the managed care organizations to a single statewide entity (SE).

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

A. Definitions beginning with letter "A":

[~~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.

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

[~~C.~~] (3) **Appeal:** A request from a member or provider for review by the managed care organization (MCO) [~~of an MCO action~~] or the single statewide entity (SE) for behavioral health of an MCO/SE action as defined above in Paragraph (2) of Subsection A of 8.305.1.7 NMAC.

[~~D.~~] (4) **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) and/or level of care.

[~~E.~~] (5) **Assignment algorithm:** [~~A mathematically weighted~~] Predetermined method for assigning [~~MCO~~] mandatory enrollees who do not select an MCO.

B. Definitions beginning with letter "B":

[~~F.~~] (1) **Behavioral health:** Refers to mental health and substance abuse.

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

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

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

C. Definitions beginning with letter "C":

[~~H.~~] (1) **Capitation:** A per-member, monthly payment to an [~~MCO~~] 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 in units of "per member per month" (PM/PM).

[~~I. **Care coordination:** Is a service to assist members with special health care needs, on an as needed basis. It is member centered, family focused when appropriate, culturally competent and strength based. Care coordination can help to ensure that the medical and behavioral health needs of the Salud! population are identified and services are provided and coordinated with the individual member and family if appropriate. Care coordination operates within the MCO with a dedicated care coordination staff, functioning independently, but is structurally linked to the other MCO systems, such as quality assurance, member services, and grievances.~~]

(2) **Care coordination for behavioral health:** An office-based administrative function of the SE, rather than a service, and is not separately reimbursed by behavioral health fund sources. It is not the same as case management, which is a therapeutic service provided face-to-face and primarily by subcontracted providers for only those customers/families in need of such services and in different levels of intensity depending on the customer's/family's need. Care coordination will be operated by the SE as a dedicated independent

function that is linked to the other SE systems, such as quality improvement/management, customer services, and complaints and grievances. The care coordinator coordinates services within the behavioral heath delivery system, as well as with other service providing systems. The care coordinator may interface and collaborate with the customer's case manager for those who receive case management services.

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

[~~J.~~] (4) **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.

(5) **Case management for behavioral heath:** A set of therapeutic services delivered primarily face-to-face in community settings (generally not office settings) and intended to ensure that individuals receive the services they need in a timely, appropriate, effective, efficient and coordinated fashion. Case management is designed for individuals and families who cannot otherwise access services, obtain the benefits of services, and/or reach their treatment and service goals without assistance. Case management is customer-centered, family-customer-focused when appropriate, culturally competent and strength-based. Providers are encouraged to offer this service in the communities that they serve.

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

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

[~~L.~~] (8) **Clean claim:** A manually or electronically submitted claim from a participating provider that contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside the health plan's system. A clean claim may include errors originating in the state'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.

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

[~~N.~~] (10) **CMS:** Centers for medicare and medicaid services.

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

[~~P.~~] (12) **Continuous quality improvement (CQI):** CQI is a process for improving quality that assumes opportunities for improvement are unlimited; is customer-oriented, data driven, and results in implementation of improvements; and requires continual measurement of implemented improvements and modification of improvements, as indicated.

[~~Q.~~] (13) **Cultural competence:** [~~Cultural competence is~~] A set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals, that enables them to work effectively in cross-cultural situations. Cultural competency involves the integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques and marketing programs that match an individual's culture and increase the quality and appropriateness of health care and outcomes.

D. Definitions beginning with letter "D":

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

[~~S.~~] (2) **Denial-administrative/technical:** A denial of authorization requests due to the requested procedure, service or item not being covered by medicaid or due to provider noncompliance with administrative policies and procedures established by either the [~~Salud! MCO~~] MCO/SE or the medical assistance division, except pharmaceutical services which the formulary process covers.

[~~T.~~] (3) **Denial-clinical:** A nonauthorization decision at the time of an initial request for a medicaid service based on the [~~client~~] member not meeting medical necessity for the requested service, except pharmaceutical services which are covered by the formulary process. 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.

[~~U.~~] (4) **Disenrollment, MCO initiated:** When requested by an MCO for substantial reason, removal of a medicaid member from membership in the requesting MCO, as determined by HSD, on a case-by-case basis.

[~~V.~~] (5) **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 [~~Salud!~~] MCO to a different [~~Salud!~~] MCO during a member lock-in period.

[~~W.~~] (6) **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":

[~~X.~~] (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 dys-

function of any bodily organ or part.

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

(3) **Enhanced service:** Any service offered by the MCO/SE that is beyond the standard required medicaid services.

[~~Z.~~] (4) **Enrollee:** A medicaid recipient who is currently enrolled in a managed care organization in a given managed care program.

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

[~~BB.~~] (6) **Exempt:** The enrollment status of a client who is not mandated to enroll in managed care.

[~~CC.~~] (7) **Exemption:** Removal of a medicaid member from mandatory enrollment in [~~Salud!~~] managed care and placement in the medicaid fee-for-service program. Such action is only for substantial reason, as determined by HSD on a case-by-case basis.

[~~DD.~~] (8) **External quality review organization (EQRO):** An independent organization with clinical and health services expertise that is capable of reviewing health care delivery systems and their internal quality assurance mechanisms.

F. Definitions beginning with letter "F":

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

[~~FF.~~] (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*).

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

[~~HH.~~] (4) **Fraud:** An intentional deception or misrepresentation made by an entity or person, including but not limited to, an [~~MCO~~] 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.

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

G. Definitions beginning with letter "G":

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

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

[~~LL.~~] (3) **Grievance (provider):** Oral or written statement by a provider to the [~~MCO regarding utilization management decisions and/or provider payment issues~~] MCO/SE expressing dissatisfaction with any aspect of the MCO/SE or its operations that is not an MCO/SE action.

H. Definitions beginning with letter "H":

[~~MM.~~] (1) **HCFA:** Health care financing administration. Effective 2001, now known as CMS, centers for medicare and medicaid services (CMS).

[~~NN.~~] (2) **Health plan:** A health maintenance organization (HMO), managed care organization (MCO), or third party payer or their agents.

[~~OO.~~] (3) **HIPAA:** Health Insurance Portability and Accountability Act of 1996.

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

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

I. Definitions beginning with letter "I":

[~~RR.~~] (1) [~~**Claims incurred but not reported (IBNR)**~~] **IBNR (claims incurred but not reported):** Claims for services authorized or rendered for which the MCO has incurred financial liability, but the claim has not been received by the MCO. This estimating method relies on data from prior authorization and referral systems, as well as other data analysis systems.

[~~SS.~~] (2) **Individuals with special health care needs (ISHCN):** Individuals [~~with ongoing health conditions, high or complex service utilization, or low to severe functional limitations~~] 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 - L: [RESERVED]

M. Definitions beginning with letter "M":

[~~TT.~~] (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.

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

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

[~~VV.~~] (4) **[~~MCO~~] MCO/SE appeal (member):** A request from a member or a provider, with the member's written consent, for review by the managed care organization [~~(MCO) of an MCO~~] MCO/SE of an MCO/SE action. An "[~~MCO~~] MCO/SE appeal" should not be confused with an applicant's or recipient's right to appeal an HSD fair hearing decision to state district court under the Public Assistance Appeals Act, NMSA 1978, Section 27-3-4 and pursuant to NMSA 1978, Section 39-3-1.1.

[~~WW.~~] (5) **MCO mandatory enrollee:** A client whose enrollment into an MCO is mandated.

[~~XX.~~] (6) **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.

[~~YY.~~] (7) [~~**Medical**~~] **Medical/clinical home:** A conceptual model that facilitates the provision of quality care that is accessible, family-centered, continuous, coordinated, compassionate and culturally competent.

[~~ZZ.~~] (8) **Medically necessary services:**

[~~(1)~~] (a) Medically necessary

services are clinical and rehabilitative physical [~~, mental~~] or behavioral health services that:

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

[~~(b)~~] (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;

[~~(c)~~] (iii) are provided within professionally accepted standards of practice and national guidelines; and

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

[~~(2)~~] (b) Application of the definition:

[~~(a)~~] (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;

[~~(b)~~] (ii) the [~~MCO~~] 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: [~~(i)~~] 1) evaluating individual physical [~~, mental~~] 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; [~~(ii)~~] 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 [~~(iii)~~] 3) considering the services being provided concurrently by other service delivery systems;

[~~(c)~~] (iii) physical [~~, mental~~] 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

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

[~~AAA.~~] (9) **Member:** A client enrolled in an [~~MCO~~] MCO/SE.

[~~BBB.~~] (10) **Member month:** A calendar month during which a member is enrolled in an [~~MCO~~] MCO/SE.

N. Definitions beginning with letter "N":

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

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

O. [RESERVED]

P. Definitions beginning with letter "P":

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

[~~FFF.~~] (2) **Potential enrollee:** A medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO.

[~~GGG.~~] (3) **Pregnancy-related services:** Medically necessary medical or surgical services related to pregnancy, including procedures to terminate pregnancy.

[~~HHH.~~] (4) **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.

[~~III.~~] (5) **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.

[~~JJJ.~~] (6) **Primary care case manager :** A physician, a physician group practice, an entity that medicaid-eligible recipients employs or arranges with physicians to furnish primary care case management services or, at state option, any of the following:

[~~(1)~~] (a) a physician assistant;

[~~(2)~~] (b) a nurse practitioner; or

[~~(3)~~] (c) a certified nurse midwife.

[~~KKK.~~] (7) **Primary care provider (PCP):** A provider who agrees to manage and coordinate the care provided to members in the managed care program.

Q. [RESERVED]

R. Definitions beginning with letter "R":

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

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

[~~NNN.~~] (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 [~~medical need, than was originally requested, except pharmaceutical services which are covered by the formulary process~~] physical health (medical needs) or behavioral health (clinical needs). Authorizations for pharmaceutical services are subject to the preferred drug list (PDL) exception process.

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

[~~PPP.~~] (5) **Reinsurance:** Reinsurance is a proactive financial tool [~~which~~] that may be used by an [~~MCO~~] 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.

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

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

S. Definitions beginning with letter "S":

(1) **Single statewide entity (SE):** The entity selected by the state of New Mexico through the behavioral health collaborative to perform all contract functions defined in the behavioral health request for proposal (RFP). The SE is a single contractor selected to provide all defined service responsibilities statewide, including medicaid behavioral health benefits. The SE will administer both the medicaid managed care and medicaid fee-for-service (FFS) programs for all medicaid behavioral health

services. The SE shall be responsible for contracting with providers, paying provider claims, assuring care coordination, conducting utilization review and utilization management activities, assuring quality review and service delivery improvement, credentialing practitioners and provider agencies, privileging practitioners to deliver critical services or service approaches, evaluating and monitoring of service delivery and conducting any other administrative functions necessary to achieve the goals of the collaborative. The SE is the agent of the collaborative and shall "coordinate", "braid" or "blend" the funding, human resources and service capacity available from the various state agencies so as to increase flexibility, maximize available resources and create a seamless single behavioral health service delivery system for New Mexico.

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

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

T. Definitions beginning with letter "T":

[~~UUU.~~] (1) **Terminations of care:** The utilization management review decision made during a concurrent review, which yields a denial, based on the current service being no longer medically necessary, except pharmaceutical services, which are covered by the formulary process.

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

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

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

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.2 NMAC, Section 9, which will be effective on July 1, 2005. The Medical Assistance Division amended the section for the purpose of incorporating program changes related to the transitioning of the delivery of Medicaid behavioral health services from the managed care organizations to a single statewide entity (SE).

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

A. **Initial information:** The education of the [~~client~~] member is initiated by the eligibility determination agencies. HSD distributes information about medicaid managed care and the enrollment process to these agencies. The SE shall also distribute medicaid behavioral health information to medicaid members upon enrollment.

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

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

(1) The member handbook must include the following:

(a) [~~MCO~~] 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) [~~patient~~] member bill of rights and member responsibilities, including any restrictions on the member's freedom of choice among network providers;

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

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

(f) description of mandatory benefits;

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

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

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

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

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

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

(m) information regarding advance directives;

(n) information regarding obtaining a second opinion;

(o) information on cost sharing, if any;

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

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

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

(2) The provider directory must include the following:

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

(b) a listing of primary care and self-refer specialty providers with the identity, location, phone number, and qualifications to include area of special expertise and non-English languages spoken that would be helpful to individuals deciding to enroll; specialty providers for self-referral shall include, but not be limited to, family planning providers, point-of-entry behavioral health providers, urgent and emergency care providers, Indian health service, other Native American providers and pharmacies; and

(c) the material [~~must~~] shall be available in a manner and format that [~~may~~] can be easily understood by all identified prevalent populations.

D. **Other requirements:**

(1) The [~~MCO must~~] MCO/SE shall provide to enrolled members the member handbook and provider directory within

30 calendar days of enrollment.

(2) The handbook and directory [~~must~~] shall be provided, in a comprehensive, understandable format that takes into consideration the special needs population, and is in accordance with federal mandates and meets communication requirements delineated in 8.305.8.15 NMAC, [~~*Patient*~~] *Member Bill Of Rights*. This information may also be accessible via the internet, and be provided as requested by HSD.

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

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

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

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

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

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

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

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

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

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.3 NMAC, Sections 9, 10 and 11, which will be effective on July 1, 2005. The Medical Assistance Division amended the sections for the purpose of incorporating program changes related to the transitioning of the delivery of Medicaid behavioral health services from the managed care organizations to a single statewide entity (SE).

8.305.3.9 ELIGIBLE MANAGED CARE ORGANIZATIONS (MCO) AND THE BEHAVIORAL HEALTH SINGLE STATEWIDE ENTITY (SE): The human services department (HSD) shall award risk-based contracts to MCOs and a contract to the single SE with statutory authority to assume risk and enter into prepaid capitation agreements [~~and~~], which 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. [~~The medical and behavioral health services to be delivered under the terms of the risk-based contract are defined in 8.305.7 NMAC, *Benefit Package*.~~]

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

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

[~~C. Other methods of payment may be included in the contract such as, but not limited to, point of service reimbursement for specific program requirements.~~]

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

8.305.3.10 CONTRACT MANAGEMENT: HSD is responsible for management of the [~~managed care~~] medicaid contracts issued to [~~MCOs~~] MCOs/SE. HSD shall provide the oversight and administrative functions to ensure [~~MCO~~] MCO/SE compliance with the terms of the [~~managed care~~] 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 [~~MCOs must~~] MCOs/SE shall meet all specified terms of the medicaid [~~managed care~~] contract with HSD and the collaborative as it relates to medicaid members and services and the Health Insurance Portability and Accountability Act (HIPAA). This includes, but is not limited to, insuring confidentiality as it relates to medical records and any other health and enrollment information that identifies a particular member. [~~An MCO will~~] The MCOs/SE shall be held harmless in conversion to HIPAA electronic transmission formats when delays are the result of implementation issues at HSD.

B. **Subcontracting requirements:** The [~~MCO~~] MCO/SE may subcontract to a qualified individual or organization the provision of any service defined in the benefit package or other required [~~MCO function (except as they relate to the provision of behavioral health services). The MCO shall be legally responsible to HSD for all work performed by any MCO subcontractor. The MCO must~~] MCO/SE functions. The MCO/SE shall submit boilerplate contract language and sample contracts for various types of subcontracts. Any substantive changes to contract templates [~~must~~] shall be approved by HSD or the collaborative prior to issuance. The SE may assign, transfer, or

delegate to the sub contractual level key management functions including, but not limited to, care coordination and universal credentialing with the explicit written approval of HSD or the collaborative.

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

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

(3) **Minimum requirements:**

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

(b) subcontracts shall identify the parties of the subcontract and the parties' legal basis of operation 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; subcontracts must describe how members access services provided under the subcontract;

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

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

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

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

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

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

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

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

(m) subcontracts shall have a provision for terminating, rescinding, or canceling the contracts for violation of applicable HSD requirements;

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

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

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

(q) subcontracts shall specify the time frame for submission of encounter data to the [~~MCO~~] MCO/SE.

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

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

[8.305.3.10 NMAC - Rp 8.305.3.10 NMAC, 7-1-04; A, 7-1-05]

8.305.3.11 ORGANIZATIONAL REQUIREMENTS:

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

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

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

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

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

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

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

(3) **Business requirements:** The [~~MCO~~] MCO/SE shall have the administrative, information and other systems in place necessary to fulfill the terms of the medicaid managed care contracts. Any change in identified key [~~MCO~~] MCO/SE personnel shall conform to the requirements of the managed care contract.

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

(5) **Member services:** The [~~MCO~~] MCO/SE shall have a member services function that coordinates communication with members and acts as a member advocate. Member services shall include sufficient staff to assist members in resolving problems or making inquiries. The [~~MCO's~~] MCO's/SE's policies and procedures shall be made available on request to members or member representatives for review during normal business hours.

(6) **Consumer advisory board:** [~~The MCO shall establish a consumer advisory board that includes regional represen-~~

~~tation of members, advocates and providers.~~] The MCOs and the SE shall establish their respective consumer advisory board that includes regional representation of customers, family member, advocates and providers. The SE's behavioral health consumer advisory board shall also interact with the behavioral health planning council (BHPC) as directed by the collaborative. The MCO and the SE consumer advisory boards shall interface and collaborate with one another as appropriate.

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

(b) The [~~MCO~~] MCO/SE shall attend at least two statewide consumer driven or hosted meetings per year, of the [~~MCO's~~] 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 shall enforce contractual and state and federal regulatory requirements specified in the scope of work of the [~~medicaid managed care contact~~] contract. HSD may use the following types of sanctions for less than satisfactory or nonperformance of contract provisions:

(a) require plans of correction;

(b) impose directed plans of correction;

(c) impose [~~civil or administrative monetary penalties and fines under the following guidelines:~~] monetary penalties and/or sanctions to the extent authorized by federal or state law:

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

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

(iii) a monetary penalty, depending upon the severity of the infraction; penalty assessments shall range up to five (5) percent of the MCO's/SE's medicaid capitation payment in 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 MCO/SE to interrupt services provided to members; and

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

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

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

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

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

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

[~~(d)~~] (e) adjust automatic assignment formula;

[~~(e)~~] (f) rescind marketing consent;

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

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

[~~(h)~~] (i) deny payment;

[~~(i)~~] (j) assess actual damages;

[~~(j)~~] (k) assess liquidated damages;

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

[~~(l)~~] (m) allow members to terminate enrollment;

[~~(m)~~] (n) suspend agreement;

[~~(n)~~] (o) terminate [~~MCO~~] MCO/SE contract;

[~~(o)~~] (p) apply other sanctions and remedies specified by HSD; and

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

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

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

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

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

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

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.4 NMAC, Sections 9, 10 and 11, which will be effective on July 1, 2005. The Medical Assistance Division amended the sections for the purpose of incorporating program changes related to the transitioning of the delivery of Medicaid behavioral health services from the managed care organizations to a single statewide entity (SE).

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

A. clients eligible for both

medicaid and medicare (dual eligibles);

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

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

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

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

F. Native Americans;

G. clients eligible for medicaid category 029, family planning services only; [~~and~~]

H. women eligible for medicaid category 052, breast and cervical cancer program; and

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

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

8.305.4.10 SPECIAL SITUATIONS:

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

(1) Newborns are automatically eligible for a period of six months and are immediately enrolled with the mother's MCO if the mother is a member at the time of the child's birth, regardless of where the child is born (that is, in the hospital or at home).

(2) If the child's mother is not a member of the MCO at the time of the birth in a hospital or at home, the child is enrolled during the next applicable enrollment cycle. If such a child is hospitalized at the time of enrollment, the MCO is not responsible for the child's care until discharge.

B. **Hospitalized [~~clients: Clients who become eligible for medicaid while~~] members:** If a medicaid-eligible member is hospitalized in a general acute care, a rehabilitation or free-standing psychiatric hospital [~~are immediately eligible for enrollment in Salud!. However, the MCO is not responsible for the member's inpatient benefits (excluding newborns born to a member mother, see Subsection A of 8.305.4.10 NMAC above) until the member is discharged from the hospital or transferred to a different level of care. HSD shall pay, on a fee for service basis, those provider submitted claims related to the hospitalization until such time as the member is discharged from the hospital.~~] either at the time the member enters managed care or enters exempt status or vice versa, the MCO/SE or FFS (exempt), which was originally responsible for the hospital inpatient placement, shall remain financially responsible for the hospital-related charges until discharge or a change in the level of care. Upon discharge or change in the level of care, the member will then become the financial responsibility of the organization or entity receiving capitation payments. This does not apply to newborns born to a member mother, see Subsection A of 8.305.4.10 NMAC above. Transition services, e.g., DME supplies for the home, shall be the financial responsibility of the MCO or the SE if applicable to behavioral health.

[~~C. **Clients in treatment foster care placements:** If a child or adolescent was residing in a treatment foster care placement at the time managed care enrollment began in 1997, they shall be exempt from enrolling in an MCO until he or she is discharged from treatment foster care.~~

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

[~~(1) In compliance with federal requirements and authorizations, HSD may mandate that a Native American shall be afforded the option of participating in managed care or being covered under the primary care case management program (PCCM). Upon determination of medicaid eligibility, a Native American may choose to participate in managed care by enrolling in an MCO for the entire benefit package. By not enrolling in an MCO, the Native American chooses not to participate in a managed care plan and shall be covered under the PCCM program.~~

~~(2) In compliance with federal law and authorizations, HSD may mandate that a Native American who is receiving services under the PCCM program must choose an MCO to provide the transportation and pharmacy benefit packages only.~~]

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

[~~F.~~] E. [~~**Clients**~~] **Members placed in nursing facilities:** If a member is placed in a nursing facility for what is expected to be a long term or permanent placement, the MCO or the SE, if the placement relates to behavioral health, remains responsible for the member until the member is disenrolled by HSD.

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

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

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

[8.305.4.10 NMAC - Rp 8 NMAC 4.MAD.606.3.2, 7-1-01; A, 7-1-04; A, 7-1-05]

8.305.4.11 MANAGED CARE STATUS CHANGE: A change of medicaid eligibility for a member enrolled in an [~~MCO~~] MCO/SE may result in managed care disenrollment or change of enrollment status within the [~~MCO~~] MCO/SE.

A. **Effect of exclusion and exempt status on managed care status:** If the member's medicaid eligibility status changes so that he is no longer a mandatory [~~MCO~~] MCO/SE enrollee, the member shall be disenrolled from the [~~MCO~~] MCO/SE.

(1) **Enrollment process immedi-**

ately initiated: If a [~~client's~~] member's eligibility status changes requiring mandatory enrollment in managed care, the enrollment process shall be initiated.

(2) **Delay in automatic assignment to [~~MCO~~] MCO/SE process:**

(a) A [~~client~~] member who has been exempt by residing in a nursing facility or intermediate care facility for the mentally retarded and is discharged to live at home, shall be eligible for enrollment in managed care upon discharge.

(b) A Native American [~~client~~] member may choose to opt in to managed care at any time.

B. **Change in eligibility without change in managed care status:** If a member's eligibility category changes and enrollment in an [~~MCO~~] MCO/SE is mandatory for the new eligibility category, the member's managed care status shall not change. Members remain enrolled in the current [~~MCO~~] MCO/SE unless another change occurs which invalidates enrollment with the current [~~MCO~~] MCO/SE.

[8.305.4.11 NMAC - Rp 8 NMAC 4.MAD.606.3.3, 7-1-01; A, 7-1-04; A, 7-1-05]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.5 NMAC, Sections 9 through 13, which will be effective on July 1, 2005. The Medical Assistance Division amended the sections for the purpose of incorporating program changes related to the transitioning of the delivery of Medicaid behavioral health services from the managed care organizations to a single statewide entity (SE).

8.305.5.9 ENROLLMENT PROCESS.

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

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

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

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

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

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

(b) **Newborn enrollment:** A newborn whose mother is a member in an [~~MCO~~] MCO/SE is automatically enrolled in the mother's MCO or in the SE. The newborn remains enrolled with the mother's MCO until the mother selects a new MCO for the child.

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

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

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

(2) [~~clients in treatment foster care placement, (Subsection C of 8.305.4.10 NMAC, *clients in treatment foster care placements*);~~

~~(3)~~] [~~clients~~] members receiving hospice care, (Subsection E of 8.305.4.10 NMAC, [~~*clients*~~] *members receiving hospice services*); and

[~~(4)~~] (3) if the selection or assignment is made after the 25th day of the month and before the first full day of the following month, the enrollment begins on the first day of the second month after the selection or assignment.

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

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

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

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

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

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

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

(1) continuity of care issues;

(2) family continuity;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.305.5.10 ENROLLMENT ROSTERS: The [~~MCO~~] 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.

[8.305.5.10 NMAC - Rp 8.305.5.10 NMAC, 7-1-04; A, 7-1-05]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) other requirements specified by the state.

B. **Scope of marketing guidelines:** Marketing materials are defined as brochures and leaflets, newspaper, magazine, radio, television, billboard, [~~MCO~~] MCO/SE yellow page advertisement, web site and presentation materials used by an [~~MCO, and MCO representative or MCO~~] MCO/SE, and MCO/SE representative or MCO/SE sub-contractor to attract or retain medicaid enrollment. HSD may request, review and approve or disapprove any communication to any medicaid [~~client. MCO~~] member. HSD may request, review and approve or disapprove any communication to any medicaid member regarding behavioral health. MCO/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 [~~clients~~] members and marketing material that mentions medicaid, medical assistance, Title XIX [~~or Salud!. The MCO~~] or makes reference to medicaid behavioral health services. The MCO/SE shall notify HSD of significant format changes to advertisements. Examples of medicaid-specific materials would be those that:

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

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

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

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

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

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

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

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

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

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

(3) initiating an enrollment request on behalf of a medicaid [~~client~~] member;

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

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

(6) the use of more than nominal gifts such as diapers, toasters, infant formula or other incentives to entice medicaid [~~clients~~] 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 MCOs unless the member requests the information;

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

(11) seeking to influence enrollment in conjunction with the sale or offer-

ing of any private insurance;

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

(13) other requirements specified by HSD.

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

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

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

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

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

J. **Light refreshments for [~~clients~~] members at meetings:** The [~~MCO~~] 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 [~~clients: MCOs~~] members:** MCO/SE and their providers, with HSD approval, may disseminate marketing materials, including nominal gifts such as pens, key chains and magnets to potential members.

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

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

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

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.6 NMAC, Sections 9 through 15 and 17, which will be effective on July 1, 2005. The Medical Assistance Division amended the sections for the purpose of incorporating program changes related to the transitioning of the delivery of Medicaid behavioral health services from the managed care organizations to a single statewide entity (SE).

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

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

B. **Comprehensive network:** The [~~MCO~~] MCO/SE shall contract with the full array of providers necessary to deliver a level of care at least equal to, or better than, community norms. The [~~MCO~~] MCO/SE shall contract with a number of providers sufficient to maintain equivalent or better access than that available under medicaid fee-for-service. The [~~MCO~~] MCO/SE shall take into consideration the characteristics and health care needs of its individual medicaid populations. The [~~MCO~~] MCO/SE must contractually require that all network providers and subcontractors be in compliance with the Health Insurance Portability and Accountability Act (HIPAA). In establishing and maintaining the network of appropriate providers, the [~~MCO~~] 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 [~~MCO~~] MCO/SE shall notify HSD within five working days of unexpected changes to the composition of its provider network that negatively affects members access or the [~~MCO's~~] MCO's/SE's ability to deliver services included in the benefit package in a timely manner. Anticipated material changes in an [~~MCO~~] MCO/SE provider network shall be reported to HSD in writing within 30 days prior to the change, or as soon as the [~~MCO~~] MCO/SE knows of the anticipated change. A notice of significant change must contain:

(1) the nature of the change;

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

(3) the MCO's plan for maintaining access and the quality of member care.

D. **Required policies and procedures:** The [~~MCO~~] MCO/SE shall maintain policies and procedures on provider recruitment and termination of

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

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

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

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

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

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

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

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

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

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

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

8.305.6.10 PROVIDER QUALIFICATIONS & CREDENTIALING: The [~~MCO~~] MCO/SE shall verify that each contracted or subcontracted provider (practitioner or facility) participating in, or employed by, the [~~MCO~~] MCO/SE meets applicable federal and state requirements for licensing, certification, accreditation and recredentialing for the type of care or services within the scope of practice as defined by federal medicaid statutes and state law.

[8.305.6.10 NMAC - Rp 8 NMAC 4.MAD.606.5.2, 7-1-01; A, 7-1-05]

8.305.6.11 UTILIZATION OF OUT-OF-STATE PROVIDERS: To the extent possible, the [~~MCO~~] MCO/SE is encouraged to utilize in-state and border providers, which are defined as those providers located within 100 miles of the New Mexico border, Mexico excluded. The [~~MCO~~] MCO/SE may include out-of-state providers in the network.

[8.305.6.11 NMAC - Rp 8 NMAC 4.MAD.606.5.3, 7-1-01; A, 7-1-05]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.305.6.13 SPECIALTY PROVIDERS:

A. The [~~MCO~~] MCO/SE shall contract with a sufficient number of specialists with the applicable range of expertise to ensure that the anticipated needs of [~~MCO~~] MCO/SE members will be met within the [~~MCO~~] MCO/SE network of providers. The [~~MCO~~] MCO/SE shall have a system to refer members to providers who are not affiliated with the [~~MCO~~] MCO/SE network if providers with the necessary qualifications or certifications to provide the required care do not participate in the [~~MCO's~~] MCO's/SE's network.

B. The [~~MCO~~] MCO/SE shall have written policies and procedures for coordination of care and the arrangement and documentation of all referrals. The [~~MCO~~] MCO/SE policies and procedures shall designate the process used by the [~~MCO~~] MCO/SE to ensure that referrals for all medically necessary services are available to members. The [~~MCO~~] 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 8.305.11.9 NMAC, *Reimbursement for Women in the Third Trimester of Pregnancy*.)

D. The [~~MCO~~] MCO/SE or a specialist may initiate a change of specialists when the member's/guardian's behavior toward the specialist is such that it has made all reasonable efforts to accommodate the member /guardian and address the member's problems, but those efforts have been unsuccessful.

[8.305.6.13 NMAC - Rp 8 NMAC 4.MAD.606.5.5, 7-1-01; A, 7-1-04; A, 7-1-05]

8.305.6.14 ACCESS TO SERVICES: The [~~MCO~~] MCO/SE shall demonstrate that its network is sufficient to meet the health care needs of enrolled members. HSD [~~initially assesses~~] shall assess the sufficiency of this network throughout the contract period. The [~~MCO~~] MCO/SE shall notify HSD as required of [~~any~~] changes in the [~~MCO~~] MCO/SE network. Changes affecting member access to care shall be communicated to HSD and remedied by the [~~MCO~~] MCO/SE in an expeditious manner.

A. **Provider to member ratios:**

(1) **PCP to member ratios:** The MCO shall ensure the member caseload of any PCP in its network does not exceed 1,500 of its own [~~Salud!~~] managed care members. Exceptions to this limit may be made with the consent of the MCO and HSD. Reasons for exceeding the limit may include continuation of established care, assignment of a family unit or availability of mid-level clinicians in the practice which expand the capacity of the PCP.

(2) **Specialist to member ratios:** HSD shall not establish specific specialist to member ratios. The [~~MCO~~] MCO/SE must ensure that members have adequate access to specialty services.

B. **Compliance with specified access standards:** The [~~MCO~~] MCO/SE shall comply with all access standards delineated under the terms of the medicaid managed care contract with respect to geographic location, scheduling time and waiting times.

C. **Requirements for [~~MCO~~] MCO/SE policies and procedures:** The [~~MCO~~] MCO/SE shall maintain written policies and procedures describing how members and providers receive instructions on access to 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, network providers and members.

[8.305.6.14 NMAC - Rp 8 NMAC 4.MAD.606.5.6, 7-1-01; A, 7-1-04; A, 7-1-05]

8.305.6.15 PUBLICLY SUPPORTED PROVIDERS: The [~~MCO~~] MCO/SE shall demonstrate how it incorporates and utilizes certain publicly supported providers who serve many of the special needs of medicaid members and are considered important in maintaining continuity of care.

A. **Federally qualified health centers (FQHCs):** The [~~MCO~~] MCO/SE shall contract with FQHCs to the extent that access is required by federal law and in accordance with the Section 1915(b) waiver granted by CMS to the state. The [~~MCO~~] MCO/SE shall contract with at least one FQHC specializing in health care for the homeless in Bernalillo county and one urban Indian FQHC. An [~~MCO~~] MCO/SE with a contracted FQHC, [~~which~~] that has no capacity to accept new members does not satisfy this requirement. If an [~~MCO~~] MCO/SE cannot meet the standard for FQHC access during the medicaid managed care contract period, the [~~MCO~~] MCO/SE shall allow its members to seek care from nonparticipating FQHCs. If the [~~MCO~~] MCO/SE and the FQHC cannot reach agreement as to reimbursement for services, the [~~MCO~~] MCO/SE shall agree to pay medicaid fee-for-service rates for the service in question.

~~[B. University of New Mexico health sciences center: The MCO shall contract with the university of New Mexico health sciences center (UNMHSC) for specialty services provided by Carrie Tingley hospital and the university of New Mexico hospital, including transplants, neonate, burn and trauma, level I trauma center and other specialized pediatric services, when UNMHSC is the sole provider in the state. If the MCO and UNMHSC cannot reach agreement as to reimbursement for services, the MCO shall agree to pay medicaid fee for service rates for the services in question.~~

~~C.~~] B. **Local department of health offices:** The MCO shall contract with public health providers for services described below in Paragraph (2) of Subsection [~~C~~] B of 8.305.6.15 NMAC and those defined by state law as public health services.

(1) **Children's medical services:** The 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.

(2) **Specific requirements for local and district health offices:** The MCO must contract with local and district public health offices to provide the following services:

(a) family planning services;

(b) the MCO may require PCPs to participate in the vaccines for children (VFC) program administered by the department of health; and

(c) in addition, the MCO may contract with local and district health offices for other clinical preventive services not otherwise available in the community, such as prenatal care or perinatal case management.

(3) **Shared responsibility between MCO and public health offices:** The 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.

[~~D.~~] C. **School-based providers:** The [~~MCO~~] 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.~~] D. **State-run institutions.** The [~~MCO~~] 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. [~~These state-run institutions are Sequoyah adolescent treatment center and the CARE unit of the Las Vegas medical center, which are administered by the department of health (DOH), and Carlsbad community residential treatment center, which is administered by the children, youth and families department (CYFD).~~

~~F.~~] E. **Indian health services (IHS) and tribal health centers:** The [~~MCO~~] MCO/SE shall allow members who are Native American to seek care from IHS, tribal or urban Indian program providers defined in the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.), whether or not the provider participates as part of the MCO's or SE's provider network. The [~~MCO~~] MCO/SE may not prevent members who are IHS beneficiaries from seeking care from IHS, tribal or urban Indian providers. The MCO/SE shall enter into contracts with "essential" providers that include, but are limited to, IHS, 638 tribal programs and providers serving particular linguistic or cultural groups.

[8.305.6.15 NMAC - Rp 8 NMAC 4.MAD.606.5.7, 7-1-01; A, 7-1-04; A, 7-1-05]

8.305.6.17 PROVIDER EDUCATION AND COMMUNICATION:

A. The [~~MCO~~] MCO/SE shall establish and maintain policies and procedures governing the development and distribution of education and informational materials regarding [~~Salud!~~] managed care, including behavioral health, to its network providers. Policies and procedures shall:

(1) inform providers of the conditions of participation with the [~~MCO regarding Salud!~~] MCO/SE;

(2) inform providers of their responsibilities to the [~~MCO and to Salud!~~] MCO/SE and to medicaid members;

(3) inform providers of [~~Salud! specific~~] medicaid-specific policies and procedures, including information on primary and specialized medical care and related information and services specific to the needs of individuals with special health care needs (ISHCN) and other special populations;

(4) inform 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 providers on how to access care coordination services for physical, behavioral and social support needs, including covered benefits and services outside the benefit package;

(7) inform providers regarding the delivery of the federally mandated EPSDT services; and

(8) furnish providers with information on the [~~MCO's~~] MCO's/SE's internal provider grievance process by which providers can [~~express their dissatisfaction with the plan's actions~~] dispute an MCO/SE action and file a complaint.

B. In addition to the above, the [~~MCOs~~] MCO/SE shall:

(1) conduct an annual provider satisfaction survey, the results of which will be incorporated into the [~~MCO's~~] MCO's/SE's quality improvement (QI) program; survey results will be forwarded to HSD;

(2) actively solicit input from its network providers in an effort to improve and resolve problem areas related to the [~~Salud!~~] medicaid program; the information provided will be incorporated into the MCO's or SE's QI program; and

(3) submit an annual provider educational training schedule to HSD; the information shall include the scheduled trainings for the [~~MCO's~~] MCO's/SE's network providers [~~, including behavioral health providers. The MCO shall be able to~~]. The MCO/SE shall provide HSD 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; or media, such as films, videotaped presentations, seminars; and schedules of classroom instruction.

C. The [~~MCO~~] MCO/SE shall maintain and continue these activities with its network providers [~~, including behavioral health,~~] throughout the term of the [~~MCO~~] MCO/SE provider contractual relationship.

[8.305.6.17 NMAC - N, 7-1-01; A, 7-1-04; A, 7-1-05]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.7 NMAC, Sections 9 through 17, which will be effective on July 1, 2005. The Medical Assistance Division amended the sections for the purpose of incorporating program changes related to the transitioning of the delivery of Medicaid behavioral health services from the managed care organizations to a single statewide entity (SE).

8.305.7.9 BENEFIT PACKAGE: This part defines the medicaid benefit package for which the [~~MCO will~~] MCO/SE shall be paid fixed per-member per-month payment rates. The [~~MCO~~] MCO/SE shall cover these services. The [~~MCO~~] MCO/SE shall not delete benefits from the medicaid-defined benefit package. An MCO is encouraged to provide an enhanced benefit package, which could include health-related educational, preventive, outreach and enhanced physical [~~and behavioral health services. The MCO~~] services. The SE shall provide enhanced behavioral health services, including behavioral health-related educational and preventive services and outreach. The MCO/SE may utilize providers licensed in accordance with state and federal requirements to deliver services.

[8.305.7.9 NMAC - Rp 8.305.7.9 NMAC, 7-1-04; A, 7-1-05]

8.305.7.10 MEDICAL ASSISTANCE DIVISION PROGRAM POLICY MANUAL: The medical assistance division program policy manual contains a detailed explanation of the services covered by medicaid, limitations and exclusions to covered services and services that are not covered by medicaid [~~is found in the medical assistance division program manual~~]. The manual is the official source of information on covered and noncovered services. [~~MCOs~~] MCOs/SE shall determine their own utilization management (UM) protocols which are based on reasonable medical evidence, and are not bound by those found in the medicaid program manual. HSD may review the MCO's or SE's UM protocols.

[8.305.7.10 NMAC - Rp 8.305.7.10 NMAC, 7-1-04; A, 7-1-05]

8.305.7.11 SERVICES INCLUDED IN THE [~~SALUD!~~] MEDICAID BENEFIT PACKAGE:

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

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

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

D. **Case management services (MCO/SE):** The benefit package includes case management services necessary to meet an identified service need as detailed in 8.326.2 NMAC through 8.326.6 NMAC and 8.320.5 NMAC.

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

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

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

(3) **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*;

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

(5) **Case management services for children up to the age of three (MCO only):** Case management services for children up to the age of three who are med-

ically [~~or behaviorally~~] 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*; and

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

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

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

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

G. **Physical health services (MCO only):** The benefit package includes primary (including those provided in school-based settings) and specialty physical health services provided by a licensed practitioner performed within the scope of practice, as defined by state law and detailed in 8.310.2 NMAC, *Medical Services Providers*; 8.310.10 NMAC, *Midwife Services*; 8.310.11 NMAC, *Podiatry Services*; 8.310.3 NMAC, *Rural Health Clinic Services*; and 8.310.4 NMAC, *Federally Qualified Health Center Services*.

H. **Laboratory services (MCO or SE):** The benefit package includes laboratory services provided according to the applicable provisions of Clinical Laboratory Improvement Act (CLIA), as detailed in 8.324.2 NMAC, *Laboratory Services*. If an inpatient physical health facility provider bills for a laboratory service where the attending physician is a psychiatrist, it shall be covered under the SE. Laboratory services provided and billed by a behavioral health provider affiliated with the SE shall be covered under the SE (e.g., residential treatment center (RTC), inpatient psych hospital, mental health clinic, etc.).

I. **Diagnostic imaging and therapeutic radiology services (MCO or SE):** The benefit package includes medically necessary diagnostic imaging and radiology services, as detailed in 8.324.3 NMAC, *Diagnostic Imaging and Therapeutic Radiology Services*. If an inpatient physical health facility provider bills for a diagnostic imaging and therapeutic radiology service where the attending physician is a psychiatrist, it shall be covered under the SE. Diagnostic imaging and therapeutic services provided and billed by a behavioral health provider affiliated with the SE shall be covered under the SE (e.g., residential treatment center (RTC), inpatient psych hospital, mental health clinic, etc.).

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

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

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

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

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

O. **Pharmacy services (MCO/SE):** The benefit package includes all pharmacy and related services, as detailed in 8.324.4 NMAC, *Pharmacy Services*. The [~~MCO~~] MCO/SE shall maintain written policies and procedures governing its drug utilization review (DUR) program in compliance with all applicable federal medicaid laws. The MCO/SE shall use a single medicaid preferred drug list (PDL). The MCO shall coordinate as necessary with the SE, and the SE shall coordinate with the MCO and the member's PCP when administering pharmacy services. The SE shall be responsible for all medications 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 and treating a psychiatric disorder.

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

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

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

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

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

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

(4) development of a systematic

communication process with MCO network providers regarding screens and treatment coordination;

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

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

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

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

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

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

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

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

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

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

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

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

(a) types of family planning services available;

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

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

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

BB. **Pregnancy termination procedures (MCO only):** The benefit package includes services for the termination of pregnancy and pre- or post-decision counseling or psychological services, as detailed in 8.325.7 NMAC, *Pregnancy Termination Procedures*.

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

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

[8.305.7.11 NMAC - Rp 8.305.7.11 NMAC, 7-1-04; A, 7-1-05]

8.305.7.12 SERVICES EXCLUDED FROM THE [~~SALUD!~~] MEDICAID BENEFIT PACKAGE: The following services are not included in the [~~Salud!~~] medicaid benefit package. Reimbursement for these services shall be made by medicaid fee-for-service. However, the [~~MCO~~] MCO/SE is expected to coordinate these services, when applicable, and ensure continuity of care by overseeing PCP consultations, medical record updates and general coordination. The excluded services include the following:

A. services provided in nursing facilities or hospital swing beds to [~~clients~~] members expected to reside in those facilities on a long-term or permanent basis, as defined in 8.312.2 NMAC, *Nursing Facilities* and 8.311.5 NMAC, *Swing Bed Hospital Services;*

B. services provided in intermediate care facilities for the mentally retarded, as defined in 8.313.2 NMAC, *Intermediate Care Facilities for the Mentally Retarded*;

C. services provided pursuant to the home and community-based services waiver programs, as defined in Chapter 314, *Long Term Care Services - Waivers*;

D. emergency services to undocumented aliens defined in 8.325.10 NMAC, *Emergency Services for Undocumented Aliens*;

E. early intervention therapy and case management services, as detailed in 8.320.4 NMAC, *Special Rehabilitation Services*;

F. case management provided by the children youth and families department defined as child protective services case management and as detailed in 8.320.5 NMAC, *EPSDT Case Management*, this service shall be excluded by the SE;

G. case management provided by the children, youth and families department, as detailed in 8.326.7 NMAC, *Adult Protective Services Case Management*, this service shall be excluded by the SE;

H. case management provided by the children, youth and families department, as detailed in 8.326.8 NMAC, *Case Management for Children Provided by Juvenile Probation and Parole Officers*, this service shall be excluded by the SE;

I. services provided in the schools and specified in the individual education plan (IEP) or individualized family service plan (IFSP), as detailed in 8.320.6 NMAC, *School-Based Services for*

Recipients under 21 Years of Age; and

J. experimental or investigational procedures, technologies or therapies, as defined in 8.325.6 NMAC, *Experimental or Investigational Procedures, Technologies or Non-Drug Therapies*. Services that meet the definition of experimental or investigational are not covered under [~~Salud!~~] medicaid managed care or fee-for-service.

[8.305.7.12 NMAC - Rp 8.305.7.12 NMAC, 7-1-04; A, 7-1-05]

8.305.7.13 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*.

[8.305.7.13 NMAC - Rp 8.305.7.13 NMAC, 7-1-04; A, 7-1-05]

8.305.7.14 BEHAVIORAL HEALTH SERVICES INCLUDED IN THE SALUD! 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 and/or during an EPSDT screen. All behavioral health care services must 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. **Case management services for the medically-at-risk:** The benefit package includes case management services for individuals who are under 21 who are medically-at-risk for behavioral health conditions, as detailed in 8.320.5 NMAC, *EPSDT Case Management*.

K. **Licensed alcohol and drug abuse counselors:** The benefit package includes alcohol and drug abuse counseling, as detailed in 8.323.3 NMAC, *Licensed Alcohol and Drug Abuse Counselors*.

[8.305.7.14 NMAC - Rp 8.305.7.14 NMAC, 7-1-04; A, 7-1-05]

8.305.7.15 BEHAVIORAL HEALTH SERVICES INCLUDED IN THE BENEFIT PACKAGE FOR ADULTS ONLY: The following services which must be provided in accordance with the New Mexico Mental Health and Developmental Disabilities Code. The SE shall provide these medicaid services.

A. **Psychosocial rehabilitation:** The benefit package includes psychosocial rehabilitation services as detailed in 8.315.3 NMAC, *Psychosocial Rehabilitation Services*.

B. **Case management services for the chronically mentally ill:** The benefit package includes case management services as detailed in 8.326.4 NMAC, *Case Management Services for the Chronically Mentally Ill.*

[8.305.7.15 NMAC - Rp 8.305.7.15 NMAC, 7-1-04; A, 7-1-05]

8.305.7.16 ENHANCED SERVICES: [~~MCOs~~] MCOs/SE are encouraged to offer members a package of enhanced services. The cost of these services cannot be included when HSD determines the payment rates.

A. **Potential enhanced services:** The following are suggested enhanced services:

(1) **(MCO/SE)** anticipatory guidance provided as a part of the normal course of office visits or a health education program, including behavioral health;

(2) **(MCO only)** comprehensive prenatal services including counseling, child birth education, parenting skills and referral to other support services;

(3) **(MCO/SE)** targeting the coordination of services necessary to optimize the member's level of health and functionality;

(4) **(MCO/SE)** child abuse and neglect prevention programs;

(5) **(MCO/SE)** stress control programs;

(6) **(MCO only)** car seats for infants and children;

(7) **(MCO/SE)** culturally-traditional indigenous healers and treatments;

(8) **(MCO/SE)** smoking cessation programs;

(9) **(MCO only)** weight loss programs;

(10) **(MCO/SE)** violence prevention and referral for support services;

(11) **(MCO/SE)** substance abuse prevention and treatment, beyond the benefit package;

(12) **(MCO/SE)** respite care for care givers;

(13) **(MCO only)** structured HIV education programs;

(14) **(MCO/SE)** programs that educate members on how to most efficiently and effectively use the health care, including behavioral health care, system; [~~and~~]

(15) **(SE only)** peer support services that utilize consumers or survivors to help persons with behavioral health conditions recover and reach their full potential; agencies, facilities or groups of providers that utilize peer supporters shall carry liability insurance to cover the peer supporters; and

[~~(15)~~] (16) other enhanced services, including behavioral health enhanced services, at the MCO's or SE's discretion.

B. **Targeted enhanced services:** Other services may be made available to members based on the MCO's or SE's discretion. Eligibility for enhanced services may be based upon a set of assessment criteria to be employed by the [~~MCO~~] MCO/SE.

[8.305.7.16 NMAC - Rp 8.305.7.16 NMAC, 7-1-04; A, 7-1-05]

8.305.7.17 [~~PERSONAL CARE OPTION (PCO) SERVICES:~~ ~~The MCOs shall under the direction of HSD or its designee provide home assessments with service plans and utilization review for PCO services. If necessary, the MCOs shall provide summaries of evidence for HSD fair hearings and participation in the fair hearing process for their own MCO members and for exempt medicaid eligible members as agreed to in the contracts between HSD and the MCOs.~~] [RESERVED]

[8.305.7.17 NMAC - N, 7-1-04; Repealed, 7-1-05]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.8 NMAC, Sections 10 through 19, which will be effective on July 1, 2005. The Medical Assistance Division amended the sections for the purpose of incorporating program changes related to the transitioning of the delivery of Medicaid behavioral health services from the managed care organizations to a single statewide entity (SE).

8.305.8.10 EXTERNAL QUALITY REVIEW: HSD shall retain the services of an external quality review organization (EQRO) in accordance with Section 1902 (a) (30) [C] of the Social Security Act [~~and the MCO shall cooperate fully with that organization. The external quality review organization~~]. The managed care organizations (MCOs)/single statewide entity (SE) shall cooperate fully with the EQRO. The EQRO shall not be a competitor of the MCO.

[8.305.8.10 NMAC - Rp 8 NMAC 4.MAD.606.7.1, 7-1-01; A, 7-1-05]

8.305.8.11 BROAD STANDARDS:

A. **NCQA requirement:** The MCO shall have and maintain national committee for quality assurance (NCQA) accreditation for its medicaid product line. If the MCO is not so accredited, it will actively pursue such accreditation. The SE shall document its behavioral health accreditation status annually with HSD, including submission of its current certificate of accreditation together with a copy of the survey report.

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

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

B. **HEDIS requirement:** The [~~MCO~~] MCO/SE shall submit a copy of its audited [~~HEDIS (health plan employer data and information set)~~] health plan employer data and information set (HEDIS) data submission tool to HSD at the same time it is submitted to NCQA. The SE shall submit a copy of its audited HEDIS behavioral health data submission tool to HSD, as per the contract. The MCOs/SE are expected to use and rely upon HEDIS data as an important measure of performance for HSD. The MCOs/SE are expected to incorporate the results of each year's HEDIS data submission into their QI/QM plan. For the MCOs/SE accredited by NCQA, the data submission shall be at the same time it is submitted to NCQA. If the SE is accredited by another body other than NCQA, the HEDIS submission shall be submitted no later than June 30th of every year. The results of the [~~MCO's~~] MCO's/SE's HEDIS ® Compliance Audit ™ [~~must~~] shall accompany its data submission tool.

C. **Mental health reporting requirement:** The [~~MCO shall use the~~] SE shall be responsible for the collection and submission of a statistically valid mental health statistics improvement project (MHSIP) survey for both the medicaid adult and child family population as an annual reporting requirement [~~for behavioral health services~~]. The SE shall adhere to the established HSD survey administration and reporting process. The annual MHSIP shall also include non-survey indicators defined by HSD as part of this reporting requirement for each contract calendar year. The [~~MCOs~~] SE shall report the MHSIP data set and any additional HSD requested data [~~which~~] that are similar to that of MHSIP to HSD for each contract calendar year. The [~~MCO~~] SE shall submit to HSD a written report of the completed calculation of performance indicators [~~in a written report~~].

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

E. **Behavioral health data (SE only):** Performance indicator data shall be collected and reported for any member receiving any behavioral health service provided by a licensed or certified behavioral health practitioner (including behavioral health case managers), regardless of setting or location as required by HSD. This includes behavioral health licensed professionals, practicing within the [~~physical health plan~~] SE. Only those services provided in the primary care setting directly by the PCP are excluded. The SE shall monitor its utilization review (UR), and its findings shall be reported to HSD regularly.

F. **Provision of emergency services:** The [~~MCO~~] MCO/SE 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).

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

H. The MCO/SE agrees to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. Section 7401 et. seq. and the Federal Water Pollution Control Act, as amended and codified at 33 U.S.C. Section 1251 et. seq.. In addition to any and all remedies and/or penalties set forth in this agreement, any violation of this provision shall be reported to the HHS and the appro-

priate regional office of the environmental protection agency.

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

8.305.8.12 STANDARDS FOR QUALITY MANAGEMENT AND IMPROVEMENT:

A. **Program structure:** Quality management is an integrated approach that links knowledge, structure and processes together throughout an MCO's/SE's system to assess and improve quality. The goal of quality improvement activities is to improve the quality of clinical care and services provided to members in the areas of health care delivery as well as supportive administrative systems. The [~~MCO's~~] MCO's/SE's quality management and improvement (QI) structures and processes shall be planned, systematic, clearly defined, and at least as stringent as federal requirements; responsibilities shall be assigned to appropriate individuals. The QI program for MCOs/SE shall be reviewed and approved by HSD annually. The MCO's/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 (EQR) annual evaluation, opportunities for improvement identified from the annual HEDIS indicators and the annual MHSIP survey (SE only), consumer and provider surveys, as well as any findings identified by an accreditation body such as NCQA.

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

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

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

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

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

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

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

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

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

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

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

(12) The program description or work plan shall address activities to improve health status of members with chronic conditions, including identification of such members; implementation of services and programs to assist such members in managing their conditions, including behavioral health; and informing providers about the programs and services for members assigned to them.

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

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

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

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

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

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

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

B. **Program operations:** The QI committee shall:

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

(2) have contemporaneous dated and signed minutes that reflect all QI committee decisions and actions;

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

(4) ensure that the [~~MCO~~] MCO/SE shall coordinate the 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 shall be linkage between the QI program and other management activities, such as network changes, benefits redesign, practice feedback to providers, member health education and member services, which will be documented in quarterly progress reports;

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

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

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

(9) ensure that stakeholders/members have an opportunity to provide input.

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

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

(1) recognition that opportunities for improvement are unlimited;

(2) be data driven;

(3) use member and provider input; and

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

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

(1) The [~~MCO~~] MCO/SE in accordance with NCQA [~~guidelines~~] requirements, shall conduct as part of its HEDIS reporting requirements, an annual survey of member satisfaction (CAHPS [~~H~~] or latest version of adult and child instruments) with the [~~MCO~~] MCO/SE.

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

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

(4) The [~~MCO~~] MCO/SE shall implement interventions to improve its performance.

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

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

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

F. **Health management systems:**

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

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

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

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

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

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

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

(g) The [~~MCO~~] MCO/SE shall periodically update its providers on the procedures for referral.

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

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

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

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

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

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

(f) The [~~MCO shall monitor~~] MCO/SE shall implement policies and procedures to ensure that continuity and coordination of care occur across practices [~~and~~], provider sites and between the MCOs/SE. In particular, the [~~MCO~~] MCO/SE shall coordinate, in accordance with applicable state and federal privacy laws, with other state agencies such as DOH, CYFD protective services and juvenile justice [~~and school districts, through the care coordination process.~~], corrections

community reentry services, as well as, with the schools. In addition, the SE shall coordinate services with all applicable state agencies comprising the collaborative.

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

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

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

(1) The [~~MCO~~] 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 based on reasonable medical evidence.

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

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

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

(6) The [~~MCO~~] MCO/SE shall periodically measure practitioner performance against at least three 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 MCOs shall implement targeted disease management protocols and procedures for chronic diseases and/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 and/or conditions, such as bipolar disorder, depression, and schizophrenia that are appropriate to meet the needs of the varied medicaid populations.

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

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

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

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

(1) The [~~MCO~~] MCO/SE shall implement interventions to improve practitioner and system performance as appropriate.

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

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

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

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

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

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

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

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

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

8.305.8.13 STANDARDS FOR UTILIZATION MANAGEMENT: [~~The MCO's utilization management (UM) program shall assign responsibility to appropriate individuals in order to manage the use of limited resources; to maximize the effectiveness of care by evaluating clinical appropriateness; to authorize the type and volume of services through fair, consistent and culturally competent decision making; and to assure equitable access to care. The MCO UM program will be based on clinical criteria established and implemented consistently across the state by the MCO, which is congruent with HSD's medically necessary service definition, as defined in 8.305.1 NMAC.~~] New Mexico medicaid requires appropriate utilization management (UM) standards to be implemented as well as activities to be performed so that excellent services are provided in a coordinated fashion with neither over nor under utilization. The MCO's/SE's UM programs shall be based on standard external national criteria, where available, and established clinical criteria, which are congruent with HSD's medical necessary service definition as defined in 8.305.1 NMAC and are applied consistently in UM decisions by the MCO/SE. The MCO's/SE's utilization management program shall assign responsibility to appropriately qualified, educated, trained, and experienced individuals in order to manage the use of limited resources; to maximize the effectiveness of care by evaluating clinical appropriateness; authorize the type and volume of services through fair, consistent and culturally competent decision making; and assure equitable access to care.

A. **Program design:**

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

ties.

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

(3) The description shall include the scope of the program; the processes and information sources used to determine benefit coverage; clinical necessity, appropriateness and effectiveness; policies and procedures to evaluate care [~~management~~] coordination, discharge criteria, site of services, levels of care, triage decisions and cultural competence of care 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 medicaid as set forth in 42 CFR Section 440.230.

(4) The [~~MCO~~] MCO/SE shall ensure that the services are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. The [~~MCO~~] 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 (or behavioral health) director or the QI committee.

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

B. **UM decision criteria:** To make utilization decisions, the [~~MCO~~] 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; and acceptable to the [~~MCO's~~] MCO's/SE's medical (or behavioral health) director, peer consultants and relevant local providers. The [~~MCO~~] 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 [~~MCO~~] MCO/SE must be responsible for covered services related to the following:

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

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

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

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

(5) The [~~MCO~~] MCO/SE shall provide the criteria to its providers upon request.

[~~(6) At least annually, the MCO shall evaluate the consistency with which the health care professionals involved in the utilization review apply the criteria in decision making.~~]

C. **Authorization of services:** For the processing of requests for initial and continuing authorization of services, the [~~MCO must~~] MCO/SE shall:

(1) require that its subcontractors have in place written policies and procedures;

(2) have in effect a mechanism to ensure consistent application of review criteria for authorization decisions;

(3) consult with requesting providers when appropriate.

D. **Use of qualified professionals:** Qualified health professionals shall assess the clinical information used to support UM decisions.

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

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

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

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

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

(1) For precertification of non-urgent (routine) care, the [~~MCO~~] MCO/SE shall make decisions within fourteen (14) days from receipt of request for service with a possible extension of up to fourteen (14) additional calendar days if the enrollee or the provider requests the extension or the [~~MCO~~] MCO/SE justifies to the HSD upon request a need for additional information and how the extension is in the enrollee's interest.

(2) For authorization of non-urgent care, the [~~MCO~~] MCO/SE shall notify a provider of the decision within one working day of making the decision.

(3) For authorization of non-urgent care that results in a denial, the [~~MCO~~] MCO/SE shall give the member and provider written or electronic confirmation of the decision within two working days of making the decision.

(4) For precertification of urgent care, the [~~MCO~~] MCO/SE shall make a decision and notify the provider of the decision within seventy-two hours of receipt of request.

(5) For authorization of urgent care that results in a denial, the [~~MCO~~] MCO/SE shall notify both the member and provider that an expedited appeal has already occurred.

(6) For authorization of urgent care that results in a denial, the [~~MCO~~] MCO/SE shall give the member and provider written or electronic confirmation of the decision within two working days of making the decision.

(7) For concurrent review of services, the [~~MCO~~] MCO/SE shall make decisions for:

(a) inpatient care within one working day of obtaining the necessary information and

(b) ongoing ambulatory care within 10 working days of obtaining the necessary information.

(8) For concurrent review, the [~~MCO~~] MCO/SE shall notify providers of decisions within one working day of making the decision.

(9) For concurrent review decisions that result in a denial, the [~~MCO~~] MCO/SE shall give the member and provider written or electronic confirmation within one working day of the original notification.

(10) For concurrent review decisions that result in a denial, the [~~MCO~~] MCO/SE shall notify the member and provider how to initiate an expedited appeal at the time of notification of the denial.

(11) For authorization decisions of non-urgent or urgent care, a 14-calendar-day extension may be requested by the member or provider. A 14-day extension may also be requested by the [~~MCO~~] MCO/SE. The [~~MCO~~] 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.

(12) The [~~MCO~~] MCO/SE shall provide written confirmation of its decisions within two working days of providing notification of a decision if the initial decision was not in writing.

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

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

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

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

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

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

(1) The [~~MCO~~] MCO/SE shall require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease, such as the [~~MCO's~~] MCO/SE medical director.

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

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

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

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

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

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

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

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

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

(2) An [~~MCO~~] 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.

J. **Evaluation of the UM process:** The [~~MCO~~] MCO/SE shall evaluate member and provider satisfaction with the UM process as a part of its member satisfaction survey. The [~~MCO~~] MCO/SE shall forward the evaluation results to HSD.

K. **HSD access:** HSD shall have access to the [~~MCO's~~] MCO's/SE's UM review documentation on request.

[8.305.8.13 NMAC - Rp 8 NMAC 4.MAD.606.7.4, 7-1-01; A, 7-1-04; A, 7-1-05]

8.305.8.14 STANDARDS FOR CREDENTIALING AND RECREDENTIALING: The [~~MCO~~] MCO/SE shall document the mechanism for credentialing and recredentialing of providers with whom it contracts or employs to treat members outside the in-patient setting and who fall under its scope of authority and action. This documentation shall include, but not be limited to, defining the scope of providers covered, the criteria and the primary source verification of information used to meet the criteria, the process used to make decisions and the extent of delegated credentialing or recredentialing arrangements.

A. **Practitioner participation:** The [~~MCO~~] MCO/SE shall have a process for receiving input from participating providers regarding credentialing and recredentialing of providers.

B. **Primary source verification:** At the time of credentialing the provider, the [~~MCO~~] 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 practitioner as the primary admitting facility, if applicable;

(3) valid drug enforcement agency (DEA) or controlled substance registration (CSR) certificate, if applicable;

(4) education and training of providers, including graduation from an accredited professional program and the highest training program applicable to the academic or professional degree, discipline and licensure of the practitioner;

(5) board certification if the practitioner states on the application that the practitioner is board certified in a specialty; and

(6) current, adequate malpractice insurance, according to the [~~MCO's policy and if available to providers holding that type of license,~~] MCO's/SE's policy and history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and

(7) primary source verification shall not be required for work history.

C. **Credentialing application:** The [~~MCO~~] MCO/SE shall use the HSD-approved credentialing form. The provider shall complete a credentialing application that includes a statement by the applicant regarding:

(1) ability to perform the essential functions of the positions, with or without accommodation;

(2) lack of present illegal drug use;

(3) history of loss of license and felony convictions;

(4) history of loss or limitation of privileges or disciplinary activity;

(5) sanctions, suspensions or terminations imposed by medicare or medicaid; and

(6) applicant attests to the correct-

ness and completeness of the application.

D. **External source verification:** Before a practitioner is credentialed, the [~~MCO~~] MCO/SE shall receive information on the practitioner from the following organizations and shall include the information in the credentialing files:

(1) national practitioner data bank, if applicable to the practitioner type;

(2) information about sanctions or limitations on licensure from the following agencies, as applicable:

(a) state board of medical examiners, state osteopathic examining board, federation of state medical boards or the department of professional regulations;

(b) state board of chiropractic examiners or the federation of chiropractic licensing boards;

(c) state board of dental examiners;

(d) state board of podiatric examiners;

(e) state board of nursing;

(f) the appropriate state licensing board for other practitioner types, including behavioral health; and

(g) other recognized monitoring organizations appropriate to the practitioner's discipline.

(3) sanctions by medicare and medicaid, as applicable.

E. **Evaluation of practitioner site and medical records.** At the time of credentialing the MCO shall perform an initial visit to the offices of potential primary care providers, obstetricians, and gynecologists [~~and~~]. The SE shall perform an initial visit to the offices of potential high volume behavioral health care practitioners, prior to acceptance and inclusion as participating providers. The [~~MCO~~] MCO/SE shall determine its method for identifying high volume behavioral health [~~practitioner~~] practitioners.

(1) The [~~MCO~~] MCO/SE shall document a structured review to evaluate the site against the MCO's organizational standards and those specified by the managed care contract.

(2) The [~~MCO~~] MCO/SE shall document an evaluation of the medical record keeping practices at each site for conformity with the [~~MCO's~~] MCO's/SE's organizational standards.

F. **Recredentialing:** The [~~MCO~~] MCO/SE shall have formalized recredentialing procedures.

(1) The [~~MCO~~] MCO/SE shall formally recredential its providers at least every three years. During the recredentialing process the [~~MCO~~] 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 practitioner as the primary admitting facility;

(c) valid DEA or CSR certificate, if applicable;

(d) board certification, if the practitioner was due to be recertified or became board certified since last credentialed or recredentialed;

(e) history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and

(f) a current, signed attestation statement by the applicant regarding:

(i) ability to perform the essential functions of the position, with or without accommodation;

(ii) lack of current illegal drug use;

(iii) history of loss or limitation of privileges or disciplinary action; and

(iv) current professional malpractice insurance coverage.

(2) There shall be evidence that, before making a recredentialing decision, the MCO has received information about sanctions or limitations on licensure from the following agencies, if applicable:

(a) the national practitioner data bank;

(b) medicare and medicaid;

(c) state board of medical examiners, state osteopathic examining board, federation of state medical boards or the department of professional regulations;

(d) state board of chiropractic examiners or the federation of chiropractic licensing boards;

(e) state board of dental examiners;

(f) state board of podiatric examiners;

(g) state board of nursing;

(h) the appropriate state licensing board for other practitioner types; and

(i) other recognized monitoring organizations appropriate to the practitioner's discipline.

(3) The [~~MCO~~] MCO/SE shall incorporate data from the following sources in its recredentialing decision-making process for providers:

(a) member [~~complaints~~] grievances and appeals;

(b) information from quality management and improvement activities; and

(c) medical record reviews conducted [~~as part of~~] under Subsection E of 8.305.8.14 NMAC.

G. **Imposition of remedies:** The [~~MCO~~] MCO/SE shall have policies and procedures for altering the conditions of the practitioner's participation with the [~~MCO~~] MCO/SE based on issues of quality of care and service. These policies and procedures shall define the range of actions that the [~~MCO~~] MCO/SE may take to improve the provider's performance prior to termination.

(1) The [~~MCO~~] MCO/SE shall have procedures for reporting to appropriate authorities, including HSD, serious quality deficiencies that could result in a practitioner's suspension or termination.

(2) The [~~MCO~~] MCO/SE shall have an appeal process by which the [~~MCO~~] MCO/SE may change the conditions of a practitioner's participation based on issues of quality of care and service. The [~~MCO~~] MCO/SE shall inform providers of the appeal process in writing.

H. **Assessment of organizational providers:** The [~~MCO~~] MCO/SE shall have written policies and procedures for the initial and ongoing assessment of organizational providers with whom it intends to contract or which it is contracted. Providers include, but are not limited to, hospitals, home health agencies, nursing facilities, free-standing surgical centers, behavioral, psychiatric and addiction disorder facilities or services, residential treatment centers, clinics, 24-hour programs, behavioral health units of general hospitals and free-standing psychiatric hospitals. At least every three years, the [~~MCO~~] MCO/SE shall confirm that the provider is in good standing with state and federal regulatory bodies, including HSD and, has been accredited or certified by the appropriate accrediting body and state certification agency or has met standards of participation required by the [~~MCO~~] MCO/SE.

(1) The [~~MCO~~] MCO/SE shall confirm that the provider has been certified by the appropriate state certification agency, when applicable. Behavioral health organizational providers and services are certified by the following:

(a) DOH is the certification agency for organizational services and providers [~~requiring~~] that require certification, except for child and adolescent behavioral health services; and

(b) CYFD is the certification agency for child and adolescent behavioral health organizational services and providers that require certification.

(2) The [~~MCO~~] MCO/SE shall confirm that the provider has been accredited by the appropriate accrediting body or has a detailed written plan that could reasonably be expected to lead to accreditation within a reasonable period of time. Behavioral health organizational providers and services are accredited by the following:

(a) adult behavioral health organizational services or providers are accredited by the council on accreditation of rehabilitation facilities (CARF);

(b) child and adolescent accredited residential treatment centers are accredit-

ed by the joint commission on accreditation of healthcare organizations (JCAHO); other child behavioral health organizational services or providers are accredited by the council on accreditation (COA); and

(c) organizational services or providers who serve adults, children and adolescents are accredited by either CARF or COA.

[8.305.8.14 NMAC - Rp 8 NMAC 4.MAD.606.7.5, 7-1-01; A, 7-1-04; A, 7-1-05]

8.305.8.15 [~~PATIENT~~] MEMBER BILL OF RIGHTS: Under medicaid managed care, members have certain rights and responsibilities and the [~~MCO~~] MCO/SE shall have policies and procedures governing member rights and responsibilities. The following subsections shall be known as the [~~"Patient~~] "Member Bill of Rights".

A. **Members' rights:**

(1) Members shall have [~~a~~] the right to be treated equitably and with respect and recognition of their dignity and need for privacy.

(2) [~~Medicaid~~] Members shall have [~~a~~] 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 [~~a~~] the right to participate with their health care providers in decision making in all aspects of their health care, including the course of treatment development, acceptable treatments and the right to refuse treatment.

(5) Members or their legal guardians shall have the right to informed consent.

(6) Members or their legal guardians shall have the right to choose a surrogate decision-maker to be involved as appropriate, to assist with care decisions.

(7) Members or their legal guardians shall have the right to seek a second opinion from a qualified health care professional within the [~~MCO~~] MCO/SE network, or the [~~MCO~~] MCO/SE shall arrange for the member to obtain [~~one~~] 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 [~~need~~] needs additional information regarding recommended treatment or believe the provider is not authorizing requested care.

(8) Members or their legal guardians shall have a right to voice grievances about the care provided by the MCO and to make use of the [~~MCO's~~] MCO's/SE's grievance process and the HSD fair hearings process without fear of retaliation.

(9) Members or their legal guardians shall have [~~a~~] the right to choose from among the available providers within the limits of the plan network and its referral and prior authorization requirements.

(10) Members or their legal guardians shall have [~~a~~] the right to make their wishes known through advance directives regarding health care decisions (e.g., living wills, right to die directives, "do not resuscitate" orders, etc.) consistent with federal and state laws and regulations.

(11) Members or their legal guardians shall have [~~a~~] 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 [~~a~~] the right to receive information about: the MCO, its health care services, how to access those services, and the [~~MCO~~] MCO/SE network providers.

(13) Members or their legal guardians shall have the right to be free from harassment by the [~~MCO~~] MCO/SE or its network providers in regard to contractual disputes between [~~MCOs~~] MCOs/SE and providers.

(14) Members have [~~a~~] 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 [~~other~~] 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 an MCO and exercise switch enrollment rights without threats or harassment.

B. **Members' responsibilities:** Members or their legal guardians shall have certain responsibilities that will facilitate the treatment process.

(1) Members or their legal guardians shall have [~~a~~] the responsibility to provide, whenever possible, information that the [~~MCO~~] MCO/SE and providers need in order to care for them.

(2) Members or their legal guardians shall have [~~a~~] 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 [~~a~~] the responsibility to follow the plans and instructions for care that they have agreed upon with their providers.

(4) Members or their legal guardians shall have [~~a~~] the responsibility to keep, reschedule or cancel an appointment rather than to simply not show up.

C. **[~~MCO~~] MCO/SE responsibilities:**

(1) The [~~MCO~~] MCO/SE shall provide a member handbook to its members and to potential members who request the handbook. The [~~MCO~~] MCO/SE shall publish in the member handbook the members' rights and responsibilities from the [~~patient~~] member bill of rights. [~~MCOs~~] MCOs/SE shall honor the provisions set forth in the [~~patient~~] member bill of rights.

(2) The [~~MCOs~~] MCO/SE shall comply with the grievance resolutions process found in 8.305.12 NMAC, *MCO Member Grievance Resolution*.

[~~(3) The MCO shall provide to members and their legal guardians the following information in writing or by telephone:~~]

(3) The [~~MCO~~] MCO/SE shall provide members or legal guardians with updated information within 30 days of a material change in the [~~MCO~~] MCO/SE provider network, procedures for obtaining benefits, the amount, duration or scope of the benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled, and information on grievance and fair hearing procedure.

(4) The [~~MCO~~] MCO/SE shall provide members and legal guardians with access to a toll-free hot line for the [~~MCO's~~] MCO's/SE's program for grievance management. The toll-free hot line for grievance management shall include the following features:

(a) requires no more than a two-minute wait except following mass enrollment periods;

(b) does not require a "touch-tone" telephone;

(c) allows communication with members whose primary language is not English or who are hearing impaired; and

(d) is in operation 24 hours per day, seven days per week.

(5) The [~~MCO~~] MCO/SE shall provide active and participatory education of members or legal guardians that takes into account the cultural, ethnic and linguistic needs of members in order to assure understanding of the health care program, improve access and enhance the quality of service provided.

(6) The [~~MCO~~] MCO/SE shall protect the confidentiality of member information and records.

(a) The [~~MCO~~] MCO/SE shall adopt and implement written confidentiality policies and procedures that conform to federal and state laws and regulations.

(b) The [~~MCO's~~] MCO's/SE's contracts with providers shall explicitly state expectations about confidentiality of member information and records.

(c) The [~~MCO~~] MCO/SE shall afford members or legal guardians the opportunity to approve or deny release by the [~~MCO~~] MCO/SE of identifiable person-

al information to a person or agency outside the [~~MCO~~] MCO/SE, except when release is required by law, state regulation [~~or~~], court order, HSD quality standards, or in the case of behavioral health, the collaborative.

(d) The [~~MCO~~] MCO/SE shall notify members and legal guardians in a timely manner when information is released in response to a court order.

(e) The [~~MCO~~] MCO/SE shall have written policies and procedures to maintain confidential information gathered or learned during the investigation or resolution of a complaint, including a member's status as a complainant.

(f) The [~~MCO~~] MCO/SE shall have written policies and procedures to maintain confidentiality of medical records used in quality review, measurement and improvement activities.

(7) When the [~~MCO~~] MCO/SE delegates member service activity, the [~~MCO~~] MCO/SE shall retain responsibility for documenting [~~MCO~~] MCO/SE oversight of the delegated activity.

(8) The [~~MCO~~] MCO/SE shall have written policies regarding the treatment of minors; adults who are in the custody of the state; adults who are the subject of an active protective services case with CYFD; children and adolescents who fall under the jurisdiction of CYFD and individuals who are unable to exercise rational judgment or give informed consent consistent with federal and state laws and New Mexico medicaid regulations. The policies regarding consent for treatment [~~for~~] of these individuals shall be disseminated to providers within the [~~MCO~~] MCO/SE network.

(9) The [~~MCO~~] MCO/SE shall have a process to detect, measure and eliminate operational bias or discrimination against [~~enrolled medicaid members by the MCO providers~~] members. The MCO/SE shall ensure that its providers and their facilities comply with the Americans with Disabilities Act..

[~~(10) The MCO shall ensure that its providers and their facilities comply with the Americans with Disabilities Act.~~]

[~~(11)~~] (10) The [~~MCO~~] 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.

[~~(12)~~] (11) The [~~MCO~~] 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.

[~~(13)~~] (12) The MCO shall not restrict a member's right to choose a provider of family planning services.

[~~(14)~~] (13) The [~~MCO's~~] MCO's/SE's communication with members shall be responsive to the various populations by demonstrating cultural competence in the materials and services provided to members. The [~~MCO~~] MCO/SE shall provide information to its network providers about culturally relevant services and may provide information about alternative treatment options, e.g., American Indian healing practices if available. Information and materials provided by the [~~MCO~~] MCO/SE to medicaid members shall be written at a sixth-grade language level and shall be made available in the prevalent population language.

[8.305.8.15 NMAC - Rp 8 NMAC 4.MAD.606.7.6, 7-1-01; A, 7-1-04; A, 7-1-05]

8.305.8.16 STANDARDS FOR PREVENTIVE HEALTH SERVICES: The [~~MCO~~] MCO/SE 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 [~~MCO~~] MCO/SE under these standards shall be adopted, reviewed at least every two years, updated when appropriate and disseminated to practitioner and member. Unless a member refuses and the refusal is documented, the [~~MCO~~] MCO/SE shall provide the following preventive health services or document that the services (with the results) were provided by other means. The [~~MCO~~] MCO/SE shall document medical reasons not to perform these services for an individual member. Member refusal is defined to include refusal to consent to and refusal to access care.

A. **Initial assessment:** The [~~MCO~~] MCO/SE shall perform an initial assessment of the medicaid member's health care needs within 90 days of the date the member enrolls in the [~~MCO~~] MCO/SE. For this purpose, a member is considered enrolled at the lock-in date.

B. **Immunizations:** The MCO shall adopt policies that to the extent possible, ensure that within six months of enrollment, members are immunized according to the type and schedule provided by current recommendations of the state department of health advisory committee on immunizations. The MCO shall provide the immunizations or verify the member's immunization history by a method acceptable to the health advisory committee.

C. **Screens:** The MCO shall adopt policies which will ensure that, to the extent possible, within six months of enrollment or within six months of a change in screening standards, asymptomatic members receive at least the following preventive screening services.

(1) *Screening for breast cancer*: Females aged 50-69 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 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 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, at a periodicity determined by the MCO.

(4) *Blood pressure measurement*: Members 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 ($\geq$10 mm of induration) must be referred to the local public health office in their community of residence for contact investigation.

(9) *Screening for rubella*: All female members of childbearing ages shall be screened for rubella susceptibility by history of vaccination or by serology.

(10) *Screening for chlamydia*: All sexually active female members age 25 or

younger shall be screened for chlamydia. All female members over age 25 shall be screened for chlamydia if they inconsistently use barrier contraception, have more than one sex partner, or have had a sexually transmitted disease in the past.

(11) *Screening for type 2 diabetes*: Individuals with one or more of the following risk factors for diabetes shall be screened. Risk factors include a family history of diabetes (parent or sibling with diabetes); obesity (≥20% over desired body weight or BMI ≥27kg/m2); race/ethnicity (e.g. Hispanic, Native American, African American, Asian-Pacific islander); previously identified impaired fasting glucose or impaired glucose tolerance; hypertension (≥140/90 mmHg); HDL cholesterol level ≤35 mg/dl and triglyceride level ≥250 mg/dl; history of gestational diabetes mellitus (GDM) or delivery of babies over 9 lbs.

(12) *Prenatal screening*: All pregnant members shall be screened for preeclampsia, D(Rh) incompatibility, down syndrome, neural tube defects, hemoglobinopathies, vaginal and rectal group B streptococcal infection and screened and counseled for HIV in accordance with the most current recommendations of the American college of obstetricians and gynecologists.

(13) *Newborn screening*: Newborn members shall be screened for those disorders specified in the state of New Mexico metabolic screen.

(14) *Tot-to-teen health checks*: The MCO shall operate a 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 [~~six~~] three months of enrollment lock-in, the MCO shall ensure that eligible members (up to age 21) are current according to the screening schedule (unless more stringent requirements are specified in these standards).

(15) Members over age 21 must be screened to detect high risk for behavioral health [~~condition at his~~] conditions at their first encounter with a PCP after enrollment.

(16) The MCO shall require PCPs to refer [~~clients, when~~] members, whenever clinically appropriate, to behavioral health providers. The [~~MCO~~] MCO/SE shall assist the member with an appropriate behavioral health referral.

(17) The MCO shall require PCPs to use standardized alcohol and drug abuse screening tools, [~~like~~] such as the CAGE (cut down, annoyed, guilty or eye opener) or AUDIT (alcohol use disorders identification test) tools, for the high risk potential population. The frequency of screening shall be determined by the results of the first screen and other clinical indicators. The SE shall require that standardized alcohol and drug abuse screening tools, such as CAGE or AUDIT, be used by its behavioral health providers for the high-risk populations.

D. **Counseling:** The [~~MCO~~] MCO/SE 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 (MCO/SE);

(2) benefits of physical activity (MCO/SE);

(3) benefits of a healthy diet (MCO/SE);

(4) prevention of osteoporosis and heart disease in menopausal women citing the advantages and disadvantages of calcium and hormonal supplementation (MCO only);

(5) prevention of motor vehicle injuries (MCO only);

(6) prevention of household and recreational injuries (MCO only);

(7) prevention of dental and periodontal disease (MCO only);

(8) prevention of HIV infection and other sexually transmitted diseases (MCO only); and

(9) prevention of unintended pregnancies (MCO only).

E. **Hot line:** The [~~MCO~~] MCO/SE shall provide a toll-free health advisor telephone hot line function 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;

(2) clinical assessment and triage to evaluate the acuity and severity of the member's symptoms and make the clinically appropriate referral;

(3) prediagnostic and post-treatment health care decision assistance based on symptoms; and

(4) preventive/wellness counseling.

F. **Family planning:** The MCO must have a family planning policy. This policy must ensure that members of the appropriate age of both sexes who seek family planning services are provided with counseling and treatment, if indicated, as it relates to the following:

(1) methods of contraception; and

(2) HIV and other sexually transmitted diseases and risk reduction practices.

G. **Prenatal care:** The MCO shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal care consistent with the standards of the American college of obstetrics and gynecology. The program shall include at least the following:

(1) educational outreach to all members of childbearing age;

(2) prompt and easy access to obstetrical care, including an office visit with a practitioner within three weeks of having a positive pregnancy test (laboratory or home) unless earlier care is clinically indicated;

(3) risk assessment of all pregnant members to identify high-risk cases for special management;

(4) counseling that strongly advises voluntary testing for HIV;

(5) case management services to address the special needs of members who have a high risk pregnancy especially if risk is due to psychosocial factors such as substance abuse or teen pregnancy;

(6) screening for determination of need for a post-partum home visit; and

(7) coordination with other services in support of good prenatal care, including transportation, other community services and referral to an agency that dispenses baby car seats free or at a reduced price.

[8.305.8.16 NMAC - Rp 8 NMAC 4.MAD.606.7.7, 7-1-01; A, 7-1-04; A, 7-1-05]

8.305.8.17 STANDARDS FOR MEDICAL RECORDS:

A. **Standards and policies:** The [~~MCO~~] MCO/SE shall require that member medical records be maintained on paper or electronic format. Member medical records shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review.

(1) The [~~MCO~~] MCO/SE shall have medical record confidentiality policies and procedures in compliance with state and federal guidelines and HIPAA.

(2) The [~~MCO~~] MCO/SE shall have medical record documentation standards that are enforced with its [~~MCO~~] 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 [~~(age, sex,~~] (date of birth, sex, race or ethnicity (if available), mailing address, residential address, employer, school, home and work telephone numbers, name and telephone numbers of emergency contacts, marital status, consent forms and guardianship information);

(c) date of data entry and date of encounter;

(d) provider identification (author of entry);

(e) allergies and adverse reactions

to medications;

(f) past medical history for patients seen [~~three~~] two or more times;

(g) status of preventive services provided or at least those specified by HSD, summarized in an auditable form (a single sheet) in the medical record within six months of enrollment;

(h) diagnostic information;

(i) medication history including what has been effective and what has not, and why;

(j) identification of current problems;

(k) history of smoking, alcohol use and substance abuse;

(l) reports of consultations and referrals;

(m) reports of emergency care, to the extent possible;

(n) advance directive for adults; and

(o) record legibility to at least a peer of the author.

(3) For patients who receive [~~three~~] two or more services from a behavioral health provider through the SE within a 12-month period, the documentation standards shall meet [~~MAD~~] medicaid requirements and require that the following items also be included in the medical record[~~, if applicable.~~] in addition to the above:

(a) a mental status evaluation [~~which~~] that documents affect, speech, mood, thought content, judgment, insight, concentration, memory and impulse control;

(b) DSM-IV diagnosis consistent with the history, mental status examination or other assessment data;

(c) a treatment plan consistent with diagnosis that has objective and measurable goals and time frames for goal attainment or problem resolution;

(d) documentation of progress toward attainment of the goal; and

(e) preventive services such as relapse prevention and stress management.

(4) The [~~MCO~~] 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 the~~] (and physical examination) for presenting complaints[~~, including~~] containing relevant psychological and social conditions affecting the patient's [~~medical and psychiatric status~~] 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 [~~should~~] shall prompt a return visit);

(g) consultations and referrals and the results; and

(h) any other significant aspect of [~~patient care~~] the member's physical or behavioral health care.

B. **Review of records:** The [~~MCO~~] MCO/SE shall have a process to systematically review provider medical records to ensure compliance with the medical record standards. The [~~MCO~~] MCO/SE shall institute improvement and actions when standards are not met.

(1) The EQRO shall conduct reviews of a representative sample of medical records from the MCO's primary care providers, obstetricians, and gynecologists [~~and~~]. The EQRO shall conduct a review of a representative sample of clinical records from the SE's behavioral health providers to determine compliance with the [~~MCO's~~] SE's established medical record standards and goals.

(2) The [~~MCO~~] MCO/SE shall have a mechanism to assess the effectiveness of organization-wide and practice-site follow-up plans to increase compliance with the [~~MCO's~~] MCO's/SE's established medical record standards and goals.

C. **Access to records:** The [~~MCO~~] MCO/SE shall provide HSD or its designee appropriate access to provider medical records.

(1) The MCO shall ensure that the PCP maintains a primary medical record for each member, which contains sufficient medical information from all providers involved in the member's care, to ensure continuity of care. The MCO shall ensure that providers involved in the member's care have access to the member's primary medical record including the SE, when necessary.

(2) The [~~MCO~~] MCO/SE shall include provisions in its contracts with providers for appropriate access to the [~~MCO's~~] MCO's/SE's members' medical records for purposes of in-state quality reviews conducted by HSD [~~or its agents~~], and for making medical records available to health care providers, including behavioral health, for each clinical encounter.

(3) The MCO shall have [~~an auditable~~] a policy that ensures the confidential transfer of medical and dental [~~or behavioral health~~] information to another primary medical, or dental [~~or behavioral health~~] practitioner whenever a primary medical or dental [~~or behavioral health~~] provider leaves the MCO [~~or whenever~~] the member changes primary medical or dental [~~or behavioral health~~] practitioner or after a [~~recipient~~] member changes enrollment from [~~the MCO to enroll~~] one MCO and enrolls in another MCO. 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. The SE shall have policies and procedures to keep the member's MCO informed of all behavioral health services provided to the MCO member. The information that shall be forwarded shall include, but not be limited to, the following:

(a) a list of the member's principal physical and behavioral health problems, as applicable;

(b) a list of 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 necessary to ensure continuity of care.

[8.305.8.17 NMAC - Rp 8 NMAC 4.MAD.606.7.8, 7-1-01; A, 7-1-04; A, 7-1-05]

8.305.8.18 STANDARDS FOR ACCESS:

A. **Ensure access:** The [~~MCO~~] MCO/SE shall establish and follow protocols to ensure the accessibility, availability and referral to health care providers for each medically necessary service. The [~~MCO must~~] MCO/SE shall submit documentation to HSD if requested, at least once per year, giving assurances that it has the capacity to serve the expected enrollment in its service area in accordance with HSD standards and in a format acceptable to HSD. The [~~MCO must~~] 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 [~~then must~~] than shall be offered.

B. **Access to urgent emergency services:** Services for emergency conditions provided by physical health providers, including emergency transportation, urgent conditions, and post-stabilization care shall be covered by the MCO only within the United States for both physical and behavioral health. The SE shall coordinate all behavioral health transportation with the member's respective MCO. An urgent condition exists when a member manifests acute symptoms and signs that, by reasonable medical judgment, represent a condition of sufficient severity that the absence of medical attention within

24 hours could reasonably result in an emergency condition. Serious impairment of biopsychosocial functioning, imminent out-of-home placement for children and adolescents or serious jeopardy to the behavioral health of the member are considered urgent conditions. An emergency condition exists when a member manifests acute symptoms and signs that, by reasonable lay person judgment, represent a condition of sufficient severity that the absence of immediate medical attention, including behavioral health, could reasonably result in death, serious impairment of bodily function or major organ [~~and~~] or serious jeopardy to the overall health of the member. Post-stabilization care means covered services related to an emergency medical or behavioral health condition, that are provided after the member is stabilized in order to maintain the stabilized condition and may include improving or resolving the member's condition.

(1) The [~~MCO~~] MCO/SE shall ensure that there is no clinically significant delay caused by the [~~MCO's~~] MCO's/SE's utilization control measures. Prior authorization is not required for emergency services in or out of the [~~MCO~~] MCO/SE network, and all emergency services shall be reimbursed at least at the medicaid fee-for-service rate. The [~~MCO~~] MCO/SE shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical or behavioral health condition under the prudent lay person standard, turned out to be non-emergency in nature.

(2) The [~~MCO~~] MCO/SE shall ensure that the member has the right to use any hospital or other licensed emergency setting for emergency care, regardless of whether the provider is contracted with the [~~MCO~~] MCO/SE.

(3) The [~~MCO~~] MCO/SE shall ensure that members have access to the nearest appropriately designated trauma center according to established EMS triage and transportation protocols.

C. **Primary care provider availability:** The MCO shall ensure that sufficient number of primary care providers are available to members to allow the members a reasonable choice among providers.

(1) The MCO shall have at least one primary care provider available per 1,500 members.

(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, [~~Rio Arriba,~~] San Miguel and Cibola. Rural counties are those that are not urban or frontier. The standards are as follows:

(a) 90% of urban residents shall travel no farther than 30 miles;

(b) 90% of rural residents shall travel no farther than 45 miles; and

(c) 90% of frontier residents shall travel no farther than 60 miles.

D. **Pharmacy provider availability:** The MCO shall ensure that a sufficient number of pharmacy providers are available to members. The MCO shall ensure that pharmacy services meet geographic access standards based on the member's county of residence. The access standards are as follows:

(1) 90% of urban residents shall travel no farther than 30 miles;

(2) 90% of rural residents shall travel no farther than 45 miles; and

(3) 90% of frontier residents shall travel no farther than 60 miles.

E. **Access to health care services:** The MCO shall ensure that there are a sufficient number of PCPs and dentists [~~and behavioral health practitioners~~] available to members to allow members a reasonable choice. The SE shall ensure that there are a sufficient number of behavioral health providers available statewide to members to allow members a reasonable choice.

(1) The MCO shall report to HSD all provider groups, health centers and individual physician[~~, dental or behavioral health~~] practices and sites in their network that are not accepting new medicaid [~~clients~~] members. The SE shall report to HSD all individual providers, provider groups, provider agencies or facilities and corresponding sites in its network that are not accepting new medicaid members.

(2) For routine, asymptomatic, member-initiated, outpatient appointments for primary medical care, the request-to-appointment time shall be no more than 30 days, unless the member requests a later time. (MCO only).

(3) For routine asymptomatic member-initiated dental appointments, the request to appointment time shall be consistent with community norms for dental appointments. (MCO only)

(4) For routine, symptomatic, member-initiated, outpatient appointments for nonurgent primary medical and dental care, the request-to-appointment time shall be no more than 14 days, unless the member requests a later time. (MCO only).

(5) For nonurgent behavioral health care, the request-to-appointment time shall be no more than 14 days, unless the member requests a later time. (SE only).

(6) Primary medical, dental and behavioral health care outpatient appointments for urgent conditions shall be available within 24 hours. (MCO/SE).

(7) 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. (MCO only).

(8) 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. (MCO/SE).

(9) 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. (MCO/SE).

(10) 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. (MCO/SE).

(11) The in-person prescription fill time (ready for pickup) shall be no longer than 40 minutes. A prescription phoned in by a practitioner shall be filled within 90 minutes. (MCO/SE).

(12) The timing of scheduled follow-up outpatient visits with practitioners shall be consistent with the clinical need. (MCO/SE).

(13) The [~~MCO~~] MCO/SE shall ensure that a medically necessary pharmaceutical agent is provided in a clinically timely manner.

(14) The [~~MCO's formulary shall use~~] MCO's/SE's preferred drug list (PDL) shall follow HSD guidelines in Subsection O of 8.305.7.11 NMAC, *Services Included in the Salud! Benefit Package*, *Pharmacy Services*.

(15) The MCO shall approve or deny a request for new durable medical equipment (DME) or for repairs to existing DME owned or rented by the member within seven working days of the request date.

(a) All new customized or made-to-measure DME or customized modifications to existing DME owned or rented by the member shall be delivered to the member within 150 days of the request date.

(b) All standard DME shall be delivered within 24 hours of the request, if needed on an urgent basis.

(c) All standard DME not needed on an urgent basis shall be delivered within a time frame consistent with clinical need.

(d) All DME repairs or non-customized modifications shall be delivered within 60 days of the request date.

(e) The MCO shall have an emergency response plan for non-customized

DME needed on an emergent basis.

(16) The MCO shall approve or deny a request for prescribed medical supplies within seven working days of the request date. The MCO shall ensure that:

(a) members can access prescribed medical supplies within 24 hours when needed on an urgent basis;

(b) members can access routine medical supplies within a time frame consistent with the clinical need;

(c) subject to any requirements to procure a physician's order to provide supplies to the member, members utilizing medical supplies on an ongoing basis shall submit to the MCO lists of needed supplies monthly; and the MCO or its subcontractor shall contact the member if the requested supplies cannot be delivered in the time frame expected and make other delivery arrangements consistent with clinical need.

(17) The [~~MCO~~] MCO/SE shall have an emergency response plan for delivery of medical supplies needed on an emergent basis.

(18) The [~~MCO~~] MCO/SE shall ensure that members and members' families receive proper instruction on the use of DME and medical supplies provided by the [~~MCO~~] MCO/SE or its subcontractor.

F. **Access to transportation services:** The MCO shall provide the transportation benefit for medically necessary [~~health services~~] physical and behavioral health. The MCO shall coordinate behavioral health transportation services with the SE, and the SE shall coordinate transportation services with the member's respective MCO. The MCO shall have sufficient transportation providers available to meet the needs of members, including an appropriate number of handivans available for members who are wheelchair or ventilator dependant or have other equipment needs. The MCO shall develop and implement policies and procedures to ensure that:

(1) transportation arranged is appropriate for the member's clinical condition;

(2) the history of services is available at the time services are requested to expedite appropriate arrangements;

(3) CPR-certified drivers are available to transport members consistent with clinical need;

(4) the transportation type is clinically appropriate, including access to non-emergency ground ambulance carriers;

(5) members can access and receive authorization for medically necessary transportation services under certain unusual circumstances without advance notification; and

(6) minors are accompanied by a parent or legal guardian as indicated to provide safe transportation.

G. **Use of technology:** The [~~MCO~~] MCO/SE is encouraged to use state-of-the-art technology, such as telemedicine, to ensure access and availability of services statewide.

[8.305.8.18 NMAC - Rp 8 NMAC 4.MAD.606.7.9, 7-1-01; A, 7-1-04; A, 7-1-05]

8.305.8.19 DELEGATION: Delegation is a process whereby an [~~MCO~~] MCO/SE gives another entity the authority to perform certain functions on its behalf. The [~~MCO~~] MCO/SE is fully accountable for all delegated activities and decisions made. The [~~MCO~~] MCO/SE shall document its oversight of the delegated activity. [~~The MCO shall not delegate behavioral health functions and activities, including quality oversight, utilization management prevention, education, outreach, grievance resolution, data collection and claims payment.~~] The SE may assign, transfer, or delegate to the sub contractual level key management functions including, but not limited to, care coordination and universal credentialing with the explicit written approval of HSD and the collaborative and as it applies to the state coverage insurance program, with the written approval of the MCO.

A. A mutually agreed upon document between [~~MCO~~] MCO/SE and the delegated entity shall describe:

(1) the responsibilities of the [~~MCO~~] MCO/SE and the entity to which the activity is delegated;

(2) the delegated activity;

(3) the frequency and method of reporting to the [~~MCO~~] MCO/SE;

(4) the process by which the [~~MCO~~] MCO/SE evaluates the delegated entity's performance; and

(5) the remedies up to, and including, revocation of the delegation, available to the [~~MCO~~] MCO/SE if the delegated entity does not fulfill its obligations.

B. The [~~MCO~~] MCO/SE shall document evidence that the [~~MCO~~] MCO/SE:

(1) evaluated the delegated entity's capacity to perform the delegated activities prior to delegation;

(2) evaluates regular reports; and

(3) evaluates at least semi-annually the delegated entity's activities in accordance with the [~~MCO's~~] MCO's/SE's expectations and [~~HSD~~] HSD's standards.

[8.305.8.19 NMAC - N, 7-1-01; A, 7-1-04; A, 7-1-05]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.9 NMAC, Sections 9 through 13, which will be effective on July 1, 2005. The Medical Assistance Division amended the sections for the purpose of incorporating program changes related to the transitioning of the delivery of Medicaid behavioral health services from the managed care organizations to a single statewide entity (SE).

8.305.9.9 COORDINATION OF SERVICES:

A. The [~~MCO~~] MCO/SE shall develop and implement policies and procedures to ensure access to care coordination for individuals with special health care needs (ISHCN) as defined in 8.305.15.9 NMAC. Care coordination is defined as a service to assist [~~clients~~] members with special health care needs, on an as needed basis. It is member-centered, family-focused when appropriate, culturally competent and strength-based. Care coordination can help to ensure that the [~~medical~~] physical and behavioral health needs of the [~~Salud!~~] medicaid population are identified and services are provided and coordinated with all service providers, individual members and family, if appropriate, and authorized by the member. Care coordination operates within the [~~MCO~~] MCO/SE with a dedicated care coordination staff functioning independently, but is structurally linked to the other [~~MCO~~] MCO/SE systems, such as quality assurance, member services and grievances. Care coordination is not "gate keeping" or "utilization management". Clinical decisions shall be based on the medically necessary covered services and not fiscal considerations. If both physical and behavioral health conditions exist, [~~the care shall be coordinated between both physical and behavioral health staff, and the responsibility for the care coordination shall be based upon what is in the best interest of the member.~~] the primary care coordination responsibility lies with the condition that is most acute. The MCO/SE responsible for the care of the most acute condition shall be primary lead on care coordination activities with necessary assistance and collaboration from both entities. Care shall be coordinated between both physical health MCO staff and behavioral health SE staff. The [~~MCO~~] MCO/SE shall use the following primary elements for care coordination:

(1) identify proactively the eligible populations;

(2) identify proactively the needs of the eligible population;

(3) provide a designated person [~~as~~] to be primarily responsible for coordi-

nating the health services furnished to a specific member and to serve as the single point of contact for the member;

(4) communicate to the member the care coordinator's name and how to contact him/her;

(5) ensure access to a qualified provider who is responsible for developing and implementing a comprehensive treatment plan as per applicable provider regulations;

(6) ensure the provision of necessary services and actively assist members and providers in obtaining
such services;

(7) ensure appropriate coordination between physical and behavioral health services and [~~non-Salud! services~~] non-managed care services; and, in the case of the SE, also coordinate care among other applicable agencies in the collaborative;

(8) coordinate with designated [~~case managers and/or medical/behavioral~~] MCO/SE care coordinators and physical or behavioral health care service providers;

[~~(9) monitor progress of the members to ensure that services are received, assist in resolving identified problems, and prevent duplication of services; and~~

~~(10) be responsible for linking individuals to case management when needed if a local case manager/designated provider is not available.~~]

(9) monitor progress of members to ensure that medically necessary services are received, to assist in resolving identified problems, and to prevent duplication of services;

(10) be responsible for linking members to MCO/SE care coordinators when needed, if a local community case manager is not available;

(11) ensure access to care coordination for all medicaid eligible ISHCN, as required by federal regulations;

(12) ensure the development of a member's individual plan of care, based on a comprehensive assessment of the goals, capacities and medical condition of the member and the needs and goals of the family; provide for an evaluation process that measures the member's response to care and ensures revision of the plan as needed;

(13) ensure the member and family shall be involved in the development of the plan of care, as appropriate; a member or family shall have the right to refuse care coordination or case management; and

(14) ensure that all MCO/SE care coordination functions include responsibility for sharing the plan of care with key providers; this information sharing is required to ensure optimum care and communication between primary care and behavioral health care, as well as among involved behavioral health providers and across other service providing systems involved with providing services to medicaid members.

B. For clarification purposes, activities provided through care coordination at the [~~MCO~~] MCO/SE level differ from case management activities provided as part of the six specific case management programs included in the medicaid benefit package. These six external case management programs shall continue to be important service components delivered as a portion of the medicaid benefit package. The case management programs are defined in 8.326.2 NMAC through 8.326.6 NMAC and 8.320.5 NMAC

[8.305.9.9 NMAC - Rp 8.305.9.9 NMAC, 7-1-04; A, 7-1-05]

8.305.9.10 COORDINATION OF PHYSICAL AND BEHAVIORAL HEALTH SERVICES BENEFITS:

A. **Coordination of physical and behavioral health services:** Physical and behavioral health services [~~must~~] shall be provided through [~~an integrated,~~] a clinically coordinated system between the MCO and SE. [~~Both physical and behavioral health care providers need access to relevant medical records of mutually served members to ensure maximum benefits of services to the member.~~] The MCO and SE shall coordinate a member's care with one another, if the member has both physical and behavioral health needs. Both physical and behavioral health care providers would benefit from having access to relevant medical records of mutually-served members to ensure the maximum benefit of services to the member. Coordination between the MCO and the SE shall require coordinated and collaborative policies and procedures to ensure effective care coordination across systems as authorized by the member. Both contractors shall be responsible for monitoring the effectiveness of referrals and coordinating with multiple providers and for the process of information sharing between the physical and behavioral health care providers. Confidentiality and HIPAA [~~laws~~] regulations apply during this coordination process.

B. **Coordination mechanisms:** [~~The MCO shall implement policies and procedures designed to maximize the coordination of physical and behavioral health services and address the medical and behavioral health needs of the member.~~] The MCO/SE shall work proactively to achieve appropriate coordination between physical and behavioral health services by implementing complimentary policies and procedures for the coordination of services. The MCO/SE shall implement policies and procedures that maximize care coordination to access medicaid services external to the MCO's program, such as the SE home and community-based waiver programs, the medicaid school-based services (MSBS) program and the children's medical services (CMS). The MCO/SE shall have procedures that ensure PCPs consistently receive communication regarding patient status and follow-up care by a specialist provider. The MCO/SE shall provide comprehensive education to its provider networks regarding HIPAA compliant protocols for sharing information between physical health, behavioral health and other providers.

C. **Referrals for behavioral health services:** [~~The PCP shall identify behavioral health needs of members and encourage and assist members in accessing behavioral health services.~~] The MCO shall educate and assist the PCPs regarding proper procedures for making appropriate referrals for behavioral health consultation and treatment through the SE.

D. **Referrals for physical health services:** [~~The behavioral health provider shall encourage and assist the member in accessing needed physical health services.~~] The SE shall educate and assist the behavioral health providers regarding proper procedures for making appropriate referrals for physical health consultation and treatment when accessing needed physical health services. The SE shall coordinate care with primary care providers.

E. **Referral policies and procedures:** The MCO/SE shall implement compatible policies and procedures that maximize care coordination to access medicaid and non-medicaid services, that are external to the MCO/SE program. The MCOs/SE shall offer statewide trainings to all providers regarding its specific referral policies and procedures. The MCOs/SE referral policies and procedures shall also be provided in provider manuals distributed to all contracted providers. The [~~MCO~~] 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, a referral from his or her MCO, or by going directly to a behavioral health provider. A written report of the outcome of any referral containing sufficient information to coordinate the member's care shall be forwarded to the PCP by the behavioral health provider with oversight from the SE within 7 calendar days after screening and evaluation.

F. **Indicators for PCP referral [~~for~~] 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 behav-

ioral 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 [~~or~~], 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 [~~and/or~~] or legal guardian of a minor for behavior health services;

(7) clinical status [~~which~~] that suggests the need for behavioral health services;

(8) identified psychosocial stressors and precipitants;

(9) treatment compliance complicated by behavioral characteristics;

(10) behavioral [~~and~~], psychiatric and/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 [~~problems~~] 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 [~~medical~~] physical health or behavioral health consultation and treatment:** The SE shall educate and assist behavioral health providers to make appropriate referrals for physical health consultation and treatment to the medicaid member's PCP and/or MCO as authorized by the member. The MCO shall educate and assist the physical health providers to make appropriate referrals for behavioral health [~~providers to make appropriate referrals for physical health~~] consultation and treatment.

H. **Independent access:** The [~~MCOs~~] MCOs/SE shall develop and implement policies and procedures that allow [~~member~~] members access to behavioral health services through the SE directly and without referral from the PCP. These policies and procedures shall require timely access to behavioral health services.

I. **Behavioral health plan of care:** [~~A~~] The behavioral health provider [~~or the PCP will~~] designated as the "clinical home" shall take responsibility for developing and implementing the member's behavioral health plan of care in coordination with the member, parent [~~and/or~~] or legal guardian and other providers, when clinically indicated. With the member's documented permission, multiple behavioral health providers [~~will~~] shall coordinate their treatment plans and progress information to provide optimum care for the member. [~~Care coordinators and case managers will be responsible for monitoring the coordination of the plan of care and information sharing for members receiving behavioral health care from multiple providers.~~] SE care coordinators and community case managers shall be responsible for monitoring the coordination of the plan of care and information sharing for members receiving behavioral health care from multiple providers.

J. **On-going reporting:**

(1) With the member's documented permission, the behavioral health provider shall keep the member's PCP informed of the following:

(a) drug therapy;

(b) laboratory and radiology results;

(c) sentinel events such as hospitalization, emergencies, and incarceration;

(d) discharge from a psychiatric hospital, residential treatment services, treatment foster care placement or from other behavioral health services; and

(e) all transitions in level of care.

(2) With the member's documented permission, the PCP shall keep the SE and behavioral health provider informed of the following:

(a) drug therapy;

(b) laboratory and radiology results;

(c) medical consultations; and

(d) sentinel events such as hospitalization and emergencies.

K. **Psychiatric consultation:** The PCP [~~and other~~], SE and all behavioral health providers are encouraged to obtain consultations and assistance with psychopharmacotherapy and diagnostic evaluations from [~~a~~] an SE contracted psychiatrist or other behavioral health specialist with prescribing authority, when clinically appropriate.

[8.305.9.10 NMAC - Rp 8.305.9.10 NMAC, 7-1-04; A, 7-1-05]

8.305.9.11 COORDINATION WITH WAIVER PROGRAMS: There are four home and community-based medicaid waiver programs. These are the developmental disabilities waiver, the disabled and elderly waiver, the medically fragile waiver and the HIV-AIDS waiver. Members participating in these waiver programs may also participate in managed care and are eligible for the [~~MCO~~] MCO/SE benefit package. In addition, the member [~~shall~~] can receive medically necessary waiver services, which are excluded from managed care. Case management is an integral part of each waiver. The waiver program is responsible for the case management function for waiver recipients. The [~~MCO~~] MCO/SE shall assist with care coordination. The [~~MCO~~] MCO/SE shall coordinate care with the member's waiver case manager to ensure that [~~ease~~] medical information is shared, following HIPAA guidelines, and that medically necessary services are provided and are not duplicated. HSD shall monitor utilization of services by waiver recipients to ensure that the [~~MCO~~] MCO/SE provides to members who are waiver participants all benefits included in the [~~Salud!~~] medicaid benefit package.

[8.305.9.11 NMAC - Rp 8.305.9.11 NMAC, 7-1-04; A, 7-1-05]

8.305.9.12 COORDINATION OF SERVICES WITH CHILDREN, YOUTH AND FAMILIES DEPARTMENT: The [~~MCO~~] 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 [~~MCO~~] MCO/SE shall assist with care coordination. Care coordination shall ensure that members receive medically necessary services, including behavioral health services through the SE, regardless of the member's custody status. If child protective services (CPS), juvenile justice division (JJD) or adult protective services (APS) 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 [~~MCO~~] MCO/SE shall designate a single contact point within the [~~MCO for these~~] MCO/SE for care coordination purposes.

A. **Children's Code compliance:** [~~These~~] The MCO/SE policies and procedures shall comply with the current New Mexico Children's Code.

B. **Adult Protective Services Act compliance:** The [~~MCO's~~]

MCO's/ 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."
[8.305.9.12 NMAC - Rp 8.305.9.12 NMAC, 7-1-04; A, 7-1-05]

8.305.9.13 COORDINATION OF SERVICES WITH SCHOOLS: The [~~MCO~~] MCO/SE shall implement policies and procedures regarding coordination with the public schools for members receiving medicaid services excluded from managed care, 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 [~~MCO~~] MCO/SE shall assist with care coordination. Coordination between the schools and the [~~MCO~~] MCO/SE shall ensure that members receive medically necessary services [~~which~~] that complement the IEP or IFSP services and promote the highest level of function for the child. The [~~MCO~~] MCO/SE shall be responsible for [~~having~~] implementing policies and procedures for coordination of services for children returning to school after extended absences, which may be due to inpatient [~~or~~], residential treatment services or treatment foster care placement.
[8.305.9.13 NMAC - Rp 8.305.9.13 NMAC, 7-1-04; A, 7-1-05]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.10 NMAC, Sections 9 through 12, which will be effective on July 1, 2005. The Medical Assistance Division amended the sections for the purpose of incorporating program changes related to the transitioning of the delivery of Medicaid behavioral health services from the managed care organizations to a single statewide entity (SE).

8.305.10.9 ENCOUNTERS: [~~MCOs~~] MCOs/SE shall submit encounter data to HSD under requirements established by HSD. CMS requires that encounter data be used for rate-setting purposes. HSD maintains oversight responsibility for evaluating and monitoring the volume, timeliness and quality of encounter data submitted by the [~~MCOs~~] MCOs/SE. If an [~~MCO~~] MCO/SE contracts with a third party to process and submit encounter data, the [~~MCO~~] MCO/SE remains responsible for the quality, accuracy and timeliness of the encounter data submitted to HSD. HSD shall communicate directly with the [~~MCO~~] MCO/SE, not with the third party contractor, regarding requirements, deficiencies, quality, accuracy and timeliness of encounter data. MCO/SE encounter data shall be used to determine compliance with performance measures and other contractual requirements, as appropriate.
[8.305.10.9 NMAC - Rp 8 NMAC 4.MAD.606.9, 7-1-01; A, 7-1-04; A, 7-1-05]

8.305.10.10 ENCOUNTER SUBMISSION MEDIA: Encounter data shall be submitted to HSD or its designee on electronic media, as designated and directed by HSD.
[8.305.10.10 NMAC - Rp 8 NMAC 4.MAD.606.9.1, 7-1-01; A, 7-1-05]

8.305.10.11 ENCOUNTER SUBMISSION TIME FRAMES: The [~~MCOs~~] MCOs/SE shall submit encounter data to HSD within 120 days of the service delivery date or discharge. HSD shall establish error thresholds, time frames and procedures for the submission, correction and resubmission of encounter data.
[8.305.10.11 NMAC - Rp 8 NMAC 4.MAD.606.9.2, 7-1-01; A, 7-1-04; A, 7-1-05]

8.305.10.12 ENCOUNTER DATA ELEMENTS: [~~Encounter data elements are based on the medicaid medicare common data initiative (medata set), which is a minimum core data set for states and MCOs developed by CMS and HSD for use in managed care. Encounter data elements are specified in the managed care contract. The human services department may increase or reduce or make mandatory or optional, data elements as it deems necessary.~~] Encounter data elements are a combination of those elements required by HIPAA-compliant transaction formats, which comprise a minimum core data set for states and MCOs/SE and those required by CMS, HSD or the collaborative for use in managed care. Encounter data elements are specified in the medicaid systems manual. HSD may increase or reduce or make mandatory or optional, data elements as it deems necessary.
[8.305.10.12 NMAC - Rp 8 NMAC 4.MAD.606.9.3, 7-1-01; A, 7-1-04; A, 7-1-05]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.11 NMAC, Section 9, which will be effective on July 1, 2005. The Medical Assistance Division amended the section for the purpose of incorporating program changes related to the transitioning of the delivery of Medicaid behavioral health services from the managed care organizations to a single statewide entity (SE).

8.305.11.9 REIMBURSEMENT FOR MANAGED CARE:

A. **Payment for services:** HSD shall make actuarially sound payments under capitated risk contracts to the designated [~~MCOs~~] MCOs/SE. Rates [~~must~~] shall be appropriate for the medicaid populations to be covered and the services to be furnished under the contract. The [~~MCO~~] MCO/SE shall be responsible for the provision of services for members during the month of capitation. Medicaid members shall not be liable for debts incurred by an [~~MCO~~] MCO/SE under the MCO's or SE's managed care contract for providing health care to medicaid members. This [~~will~~] shall include, but not be limited to:

(1) the [~~MCO's~~] MCO's/SE's debts in the event of the [~~MCO's~~] MCO's/SE's insolvency;

(2) covered services provided to the member, for which HSD does not pay the [~~MCO~~] MCO/SE, e.g., enhanced services;

(3) when HSD or the[~~MCO~~] MCO/SE does not pay the health care provider that furnishes the services under contractual, referral, or other arrangement;[~~and~~]

(4) payments for covered services furnished under contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the [~~MCO~~] MCO/SE provided the service directly; and

(5) if an MCO/SE member loses eligibility for any reason and is reinstated as eligible by HSD before the end of the month, the MCO/SE shall accept a retro capitation payment for that month of eligibility and assume financial responsibility for all medically necessary covered benefit services supplied to the member.

B. **Capitation disbursement requirements:** The [~~MCO~~] 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. A minimum of eighty-five percent (85%) of all the

[~~MCO's~~] MCO's/SE's income generated under this agreement, including but not limited to, third-party recoupments and interest, shall be expended [~~on the medical and~~] on the physical or behavioral health services required under this agreement to be provided to the [~~MCO's~~] MCO's/SE's medicaid members. If the [~~MCO~~] MCO/SE does not expend a minimum of eighty-five percent (85%) on [~~medical and behavioral services~~] physical or behavioral health services required under the agreement, HSD [~~will~~] shall withhold an amount so that the [~~MCO's~~] MCO's/SE's ratio for service expenditures [~~are~~] is eighty-five percent (85%). HSD [~~will~~] shall calculate the [~~MCO's~~] MCO's/SE's income at the end of the state fiscal year to determine if eighty-five percent (85%) was expended on the [~~medical and~~] physical or behavioral services required under the [~~agreement~~] agreement/contract, utilizing reported information from the MCO/SE and the department of insurance reports. Administrative costs, which shall be no higher than fifteen percent (15%), and other financial information shall be monitored on a regular basis by HSD. Members shall be entitled to receive all covered services for the entire period for which payment has been made by HSD. Any and all costs incurred by the [~~MCO~~] MCO/SE in excess of the capitation payment [~~will~~] shall be borne in full by the [~~MCO~~] MCO/SE. Interest generated through investment of funds paid to the [~~MCO~~] MCO/SE pursuant to this agreement shall be the property of the [~~MCO~~] MCO/SE.

C. **Payment time frames:** Clean claims as defined in Subsection L of 8.305.1.7 NMAC, *Clean Claim*, shall be paid by the [~~MCO~~] MCO/SE to contracted and noncontracted providers according to the following timeframe: 90% within 30 days of the date of receipt and 99% within 90 days of the date of receipt, as required by federal guidelines in the Code of Federal Regulations, Section 42 CFR 447.45. The date of receipt is the date the [~~MCO~~] MCO/SE receives the claim, as indicated by the [~~MCO's~~] MCO's/SE's date stamp on the claim. The date of payment is the date of the check or other form of payment. An exception to this rule may be made if the [~~MCO~~] MCO/SE and its providers, by mutual agreement, establish an alternative payment schedule; however, any such alternative payment schedule [~~must~~] shall first be incorporated into the contract between HSD and the [~~MCO~~] MCO/SE. The [~~MCO~~] MCO/SE shall promptly pay claims for all covered emergency and post-stabilization services that are furnished by non-contracted providers, including medically or clinically necessary testing to determine if a [~~medical~~] physical or behavioral health emergency exists.

(1) An [~~MCO~~] MCO/SE shall pay contracted and noncontracted providers interest on the [~~MCO's~~] MCO's/SE's liability at the rate of 1 1/2 % per month on the amount of a clean claim (based upon the current medicaid fee schedule) submitted by the participating provider and not paid within 30 days of the date of receipt of an electronic claim and 45 days of receipt of a manual claim. Interest [~~will~~] shall accrue from the 31st day for electronic claims and from the 46th day for manual claims.

(2) No contract between [~~an MCO~~] the MCO/SE and a participating provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions.

(3) If [~~an MCO~~] the MCO/SE is unable to determine liability for, or refuses to pay, a claim of a participating provider within the times specified above, the [~~MCO~~] MCO/SE shall make a good-faith effort to notify the participating provider by fax, electronic or other written communication within 30 days of receipt of the claim, stating specific reasons why it is not liable for the claim or request specific information necessary to determine liability for the claim.

D. **Rate setting:** Capitation rates paid by HSD to the [~~MCOs~~] MCO/SE for the provision of the managed care medicaid benefit package shall be calculated through actuarial analysis, be actuarially sound and meet the standards set by 42 CFR 438.6(c).

E. **Payment on risk basis:** The [~~MCO~~] MCO/SE is at risk of incurring losses if its costs of providing the managed care medicaid benefit package exceed its capitation payment. HSD shall not provide retroactive payment adjustments to the [~~MCO~~] MCO/SE to reflect the actual cost of services furnished by the [~~MCO~~] MCO/SE.

F. **Change in capitation rates:** HSD shall review the capitation rates 12 months from the effective date of the [~~managed care~~] contract and annually thereafter. HSD may adjust the capitation rates based on factors such as the following: changes in the scope of work; CMS [~~requires~~] requiring a modification of the state's waiver; if new or amended federal or state laws or regulations are implemented; [~~or~~] inflation; or if significant changes in the demographic characteristics of the member population occur.

G. **Solvency requirements and risk protections:** An [~~MCO which~~] MCO/SE that contracts with HSD to provide medicaid physical or behavioral health services shall comply with, and be subject to, all applicable state and federal laws and regulations, including solvency and risk standards. In addition to requirements imposed by state and federal law, the [~~MCO~~] MCO/SE shall be required to meet specific medicaid financial requirements and to provide to HSD [~~or its agent,~~] the information and records necessary to determine the [~~MCO's~~] MCO's/SE's financial condition. Requests for information and records shall be delivered to HSD, at no cost to HSD, in a reasonable time after the date of request or as specified in the [~~managed care~~] contract.

(1) **Reinsurance:** An [~~MCO~~] MCO/SE participating in medicaid managed care 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 [~~MCO~~] MCO/SE shall document for HSD that reinsurance is in effect through the term of the [~~medicaid managed care~~] 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 [~~Section~~] 438.6(e)(5), contract provisions for reinsurance, stop-loss limits, or other risk sharing methodologies [~~must~~] shall be computed on an actuarially sound basis.

(2) **Third party liability (TPL):** By federal law medicaid is the payer of last resort. The [~~MCO~~] MCO/SE shall be responsible for identifying a member's third party coverage and coordinating of benefits with third parties. The [~~MCO~~] MCO/SE shall inform HSD when a member has other health care insurance coverage. The MCO shall have the sole right of subrogration, for twelve (12) months, from when the MCO incurred the cost on behalf of the members, to initiate recovery or to attempt to recover any third-party resources available to medicaid members and shall make records pertaining to third party collections (TPL) for members available to HSD/MAD for audit and review. If the MCO has not initiated recovery or attempted to recover any third-party resources available to medicaid members within twelve (12) months. HSD will pursue the member's third party resources. The [~~MCO~~] MCO/SE shall provide to HSD for audit and review all records pertaining to TPL collections for members.

(3) **Fidelity bond requirement:** The [~~MCO~~] MCO/SE shall maintain a fidelity bond in the maximum amount specified under the Insurance Code.

(4) **Net worth requirement:** The [~~MCO~~] MCO/SE shall comply with the net worth requirements of the Insurance Code.

(5) **Solvency cash reserve requirement:** The [~~MCO~~] MCO/SE shall have sufficient reserve funds available to ensure that the provision of services to medicaid members is not at risk in the event of [~~MCO~~] MCO/SE insolvency.

(6) **Per enrollee cash reserve:** The [~~MCO~~] MCO/SE shall maintain three (3) percent of the monthly capitation payments per member with an independent trustee during each month of the first year of the agreement; provided, however, that if this agreement replaces or extends a previous agreement with HSD to provide medicaid managed care, then continued maintenance of the per member cash reserve established and maintained by the [~~MCO~~] MCO/SE pursuant to such previous agreement shall be the agreement. HSD shall adjust this cash reserve requirement annually, or as needed, based on the number of the [~~MCO~~] MCO's/SE's members. Each [~~MCO~~] MCO/SE shall maintain its own cash reserve account. This account may be accessed solely for payment for services to the [~~MCO~~] MCO's/SE's members in the event that the [~~MCO~~] MCO/SE becomes insolvent. Money in the reserve account remains the property of the [~~MCO~~] MCO/SE, and any interest earned (even if retained in the account) shall be the property of the [~~MCO~~] MCO/SE.

H. **Inspection and audit for solvency requirements:** The [~~MCO~~] MCO/SE shall meet all requirements for state licensure with respect to inspection and auditing of financial records. The [~~MCO~~] MCO/SE shall cooperate with HSD, or its designee to provide all financial records required by HSD. HSD, or [~~its designee~~] their designees may inspect and audit the [~~MCO's~~] MCO's/SE's financial records at least annually, or more frequently, if deemed necessary.

I. **Special payment requirements:** This section lists special payment requirements by provider type.

(1) **Reimbursement for FQHCs:** Under federal law, FQHCs shall be reimbursed at 100% of reasonable cost under a medicaid fee-for-service or managed care program. The FQHC may waive its right to 100% of reasonable cost and elect to receive a rate negotiated with the [~~MCO~~] MCO/SE. HSD shall provide a discounted wrap-around payment to FQHCs that have waived a right to 100% reimbursement of reasonable cost from the [~~MCO~~] MCO/SE.

(2) **Reimbursement for providers furnishing care to Native Americans:** If an Indian health service (IHS) or tribal 638 provider delivers services to an [~~MCO~~] MCO/SE member who is Native American, the [~~MCO~~] MCO/SE shall reimburse the provider at the rate currently established by the office of management and budget (OMB) for specified services for the IHS facilities, or the medicaid fee-for-service rate for all other services or at a fee negotiated between the provider and the [~~MCO~~] MCO/SE.

(3) **Reimbursement for family planning services:** The MCOs shall reimburse out-of-network family planning providers for services provided to MCO members at a rate at least equal to the medicaid fee-for-service rate for the provider type.

(4) **Reimbursement for women in the third trimester of pregnancy:** If a woman in the third trimester of pregnancy at the time of her enrollment in [~~Salud!~~] managed care has an established relationship with an obstetrical provider and desires to continue that relationship and the provider is not contracted with the MCO, the MCO shall reimburse the out-of-network provider for care directly related to the pregnancy, including delivery and a six-week post-partum visit.

(5) **Reimbursement for members who disenroll while hospitalized:** [~~If the member is hospitalized at the time of disenrollment, the MCO shall be responsible for payment of all covered inpatient facility and professional services form the date of admission to the date of discharge. The MCO shall be responsible for ensuring proper transition of care if the member is to be enrolled with another MCO.~~] If a medicaid member is hospitalized at the time of disenrollment, the organization MCO/SE or FFS exempt, which was originally responsible for the hospital 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) **Reimbursement for personal care option assessment/utilization review management services:** Payment for PCO services provided by the MCO to manage PCO utilization shall be paid to the MCO on a negotiated fee-for-service basis.~~

~~(7) **Reimbursement for non-Salud! Native Americans:** The MCO shall be paid a negotiated capitated per member per month rate to provide the transportation and pharmacy benefits to non-Salud! Native American enrollees not currently in long-term care services.~~

~~(8) **Reimbursement for primary care case management:** The provider/agency contracted for primary care case management shall receive a negotiated per member per month fee-for-services rendered.~~

~~(9)~~] (6) **Sanctions for noncompliance:** The department may impose sanctions against an [~~MCO~~] MCO/SE that fails to meet the financial requirements specified in this section or additional requirements specified in the terms of the medicaid managed care contract or federal medicaid law.

J. **Recoupment payments:** HSD shall have the discretion to recoup payments for MCO members who are incorrectly enrolled with more than one MCO, including members categorized as newborns or X5; payments made for MCO/SE members who die prior to the enrollment month for which payment was made; and/or payments to the MCO/SE for members whom HSD later determines were not eligible for medicaid during the enrollment month for which payment was made. Any duplicate payment identified by either the [~~MCO~~] MCO/SE or HSD [~~will~~] shall be recouped upon identification. [~~Notwithstanding the foregoing, in the absence of fraud on the part on the MCO, HSD shall not have the right to recoup any payment to the MCO if either the MCO (and/or its subcontractors) provided any health care services to the member during the 60 days following the first day of any month for which payment was made or more than twenty-four months have elapsed since the payments were made unless HSD is required by federal agency to go beyond the twenty-four month period.~~] HSD periodically shall recoup capitations for individuals who should not have been enrolled with the MCO/SE. If the MCO/SE has incurred provider expense for the individual for the month of capitation, reconciliation shall be done. If no expense has been incurred, the entire capitation shall be recouped by HSD. To allow for claim submission lags, HSD [~~will~~] shall not request a payment recoupment until 120 days have elapsed from the date [~~of~~] on which the enrollment/claims payment error was made. In the event of an error, which causes payment(s) to the [~~MCO~~] MCO/SE to be issued by HSD, the [~~MCO~~] MCO/SE shall reimburse the state within thirty (30) days of written notice of such error for the full amount of the payment, subject to the provisions of Section 5.6 (4) of the agreement. Interest shall accrue at the statutory rate on any amounts not paid and determined to be due after the thirtieth (30^{th}) day following the notice. Any process that automates the recoupment procedures [~~will~~] shall be mutually agreed upon in advance by HSD and the [~~MCO~~] MCO/SE and documented in writing, prior to implementation of the new automated recoupment process. The [~~MCO~~] MCO/SE has the right to dispute any recoupment request in accordance with Article 15 (DISPUTES).

K. HSD shall pay interest at 9% per annum on any capitation payment due to the [~~MCO~~] MCO/SE that is more than 30 days late. No interest or penalty shall accrue for any other late payments or reimbursements.

L. HSD may initiate alternate payment methodology for specified program services or responsibilities.

[8.305.11.9 NMAC - Rp 8 NMAC 4.MAD.606.10, 7-1-01; A, 7-1-04; A,

7/1/05]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.12 NMAC, Sections 9 through 16, which will be effective on July 1, 2005. The Medical Assistance Division amended the sections for the purpose of incorporating program changes related to the transitioning of the delivery of Medicaid behavioral health services from the managed care organizations to a single statewide entity (SE).

8.305.12.9 GRIEVANCE SYSTEM:

A. The [~~MCO~~] MCO/SE shall have a grievance system in place for members that includes a grievance process related to dissatisfaction and an appeals process related to an [~~MCO~~] MCO/SE action, including the opportunity to request an HSD fair hearing.

B. A grievance is a member's expression of dissatisfaction about any matter or aspect of the [~~MCO~~] MCO/SE or its operation, other than an [~~MCO action~~] MCO/SE action, as defined below.

C. An appeal is a request for review by the [~~MCO of an MCO~~] MCO/SE of an MCO/SE action. An action is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure to provide services in a timely manner. An untimely service authorization constitutes a denial and is thus considered an action.

D. The member, legal guardian of the member for [~~minors or~~] a minor or an incapacitated [~~adults~~] adult, or a representative of the member as designated in writing to the [~~MCO~~] MCO/SE, has the right to file a grievance or an appeal of an [~~MCO~~] MCO/SE action on behalf of the member. A provider acting on behalf of the member, [~~and~~] with the member's written consent, may file a grievance and/or an appeal of an [~~MCO~~] MCO/SE action.

E. In addition to the [~~MCO~~] MCO/SE grievance and appeal process described above, a member, legal guardian of the member for a minor or an incapacitated adult, or the representative of the member has the right to request a fair hearing on behalf of the member with HSD directly as described in 8.352.2. NMAC, *Fair Hearings,* if an [~~MCO~~] MCO/SE decision results in termination, modification, suspension, reduction, or denial of services to the member or if the member believes the [~~MCO~~] MCO/SE has taken an action erroneously. A fair hearing may be requested prior to, concurrent with, subsequent to, or in lieu of a grievance or appeal to [~~an MCO~~] the MCO/SE.

[8.305.12.9 NMAC - Rp 8.305.12.9 NMAC, 7-1-04; A, 7-1-05]

8.305.12.10 GENERAL REQUIREMENTS FOR GRIEVANCE AND APPEALS:

A. The [~~MCO~~] MCO/SE shall implement written policies and procedures describing how the member may [~~register~~] submit a request for a grievance or an appeal with the [~~MCO or register~~] MCO/SE or submit a request for a fair hearing with HSD. The policy [~~should~~] shall include a description of how the [~~MCO~~] MCO/SE resolves the grievance or appeal.

B. The [~~MCO~~] MCO/SE shall provide to all service providers in the [~~MCO's~~] MCO's/SE's network a written description of the [~~MCO's~~] MCO's/SE's grievance and appeal process and how the provider can submit a grievance and/or appeal.

C. The [~~MCO~~] MCO/SE shall have available reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

D. The [~~MCO~~] MCO/SE shall name a specific individual(s) designated as the [~~MCO's~~] MCO's/SE's medicaid member grievance coordinator with the authority to administer the policies and procedures for resolution of a grievance and/or an appeal, to review patterns/trends in grievances and/or appeals, and to initiate corrective action.

E. The [~~MCO~~] MCO/SE shall ensure that the individuals who make decisions on grievances and/or appeals are not involved in any previous level of review or decision-making. The [~~MCO~~] MCO/SE shall also ensure that health care professionals with appropriate clinical expertise shall make decisions for the following:

(1) an appeal of an [~~MCO~~] MCO/SE denial that is based on lack of medical necessity;

(2) an [~~MCO~~] MCO/SE denial that is upheld in an expedited resolution;

(3) a grievance or appeal that involves clinical issues.

F. Upon enrollment, the [~~MCO~~] MCO/SE shall provide members, at no cost, with a member information sheet or handbook that provides information on how they and/or their representative(s) can file a grievance and/or an appeal, and the resolution process. The member information shall also advise members of their right to file a request for an administrative hearing with the HSD hearings bureau, upon notification of an [~~MCO~~] MCO/SE action, or concurrent with or following an appeal of the [~~MCO~~] MCO/SE action. The information shall meet the standards [~~for communication specified in MAD policy 8.305.8.15.(13)~~] specified in Paragraph (15) of Subsection C of 8.305.8.15 NMAC.

G. The [~~MCO must~~] MCO/SE shall ensure that punitive or retaliatory action is not taken against a member or a provider that files a grievance and/or an appeal, or a provider that supports a member's grievance and/or appeal.

[8.305.12.10 NMAC - Rp 8.305.12.10 & 11 NMAC, 7-1-04; A, 7-1-05]

8.305.12.11 GRIEVANCE: A grievance is a member's expression of dissatisfaction about any matter or aspect of the [~~MCO~~] MCO/SE or its operation other than an [~~MCO~~] MCO/SE action.

A. A member may file a grievance either orally or in writing with the [~~MCO~~] MCO/SE within 90 calendar days of the date of the event causing the dissatisfaction occurred. The legal guardian of the member for [~~minors or incapacitated adults~~] a minor or an incapacitated adult, a representative of the member as designated in writing to the [~~MCO~~] MCO/SE, and a 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 (5) working days of receipt of the grievance, the [~~MCO~~] 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 [~~MCO~~] MCO/SE resolution process for grievances shall be completed within thirty (30) calendar days of the date the grievance is received by the [~~MCO~~] MCO/SE and shall include a resolution letter to the grievant.

D. The [~~MCO~~] MCO/SE may request an extension from HSD of up to fourteen (14) calendar days if the member requests the extension, or the [~~MCO~~] MCO/SE demonstrates to HSD that there is need for additional information, and the extension is in the member's interest. For any extension not requested by the member, the [~~MCO~~] MCO/SE shall give the member written notice of the reason for the extension within two (2) working days of the decision to extend the timeframe.

E. Upon resolution of the grievance, the [~~MCO~~] MCO/SE shall mail a resolution letter to the member. The resolution letter [~~must~~] 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.

[8.305.12.11 NMAC - Rp 8.305.12.9 NMAC, 7-1-04; A. 7-1-05]

8.305.12.12 APPEALS: An appeal is a request for review by the [~~MCO~~] MCO/SE of an [~~MCO~~] MCO/SE action.

A. [~~Action~~] An action is defined as:

(1) the denial or limited authorization of a requested service, including the type or level of service;

(2) the reduction, suspension, or termination of a previously authorized service;

(3) the denial, in whole or in part, of payment for a service;

(4) the failure of the [~~MCO~~] MCO/SE to provide services in a timely manner, as defined by HSD; or

(5) the failure of the [~~MCO~~] MCO/SE to complete the authorization request in a timely manner as defined in 42 CFR [~~Section~~] 438.408.

B. **Notice of [~~MCO~~] MCO/SE action:** The [~~MCO~~] MCO/SE shall mail a notice of action to the member and/or provider within 10 days of the date of [~~an~~] the action, except for denial of claims [~~which~~] that may result in [~~client~~] member financial liability, which requires immediate notification. The notice [~~must~~] shall contain, but not be limited to, the following:

(1) the action the [~~MCO~~] MCO/SE has taken or intends to take;

(2) the reasons for the action;

(3) the member's or the provider's right to file an appeal of the [~~MCO~~] MCO/SE action through the [~~MCO~~] 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, how to request the continuation of benefits, and the circumstances under which the member may be required to pay the costs of continuing these benefits.

C. A member may file an appeal of an [~~MCO~~] MCO/SE action within 90 calendar days of receiving the [~~MCO~~] MCO's/SE's notice of action. The legal guardian of the member for [~~minors or incapacitated adults~~] a minor or an incapacitated adult, a representative of the member as designated in writing to the [~~MCO~~] MCO/SE, or a provider acting on behalf of the member with the member's written consent, have the right to file an appeal of an action on behalf of the member.

D. The [~~MCO~~] MCO/SE has thirty (30) calendar days from the date the initial oral or written appeal is received by the [~~MCO~~] MCO/SE to resolve the appeal.

E. The [~~MCO~~] MCO/SE shall have a process in place that [~~that assures~~] 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 [~~must~~] shall be followed by a written appeal within 10 calendar days that is signed by the member. [~~The MCO will make~~] The MCO/SE shall use its best efforts to assist members as needed with the written appeal.

F. Within five (5) working days of receipt of the appeal, the [~~MCO~~] MCO/SE shall provide the grievant with written notice that the appeal has been received and the expected date of its resolution. The [~~MCO~~] MCO/SE shall confirm in writing receipt of oral appeals, unless the member or the provider requests an expedited resolution.

[~~G. The MCO has thirty (30) calendar days from the date the oral or written appeal is received by the MCO to resolve the appeal.~~

~~H.~~] G. The [~~MCO~~] MCO/SE may extend the [~~thirty~~] 30-day timeframe by 14 calendar days if the member requests the extension, or the [~~MCO~~] MCO/SE demonstrates to HSD that there is need for additional information, and the extension is in the member's interest. For any extension not requested by the member, the [~~MCO must~~] MCO/SE shall give the member written notice of the extension and the reason for the extension within two (2) working days of the decision to extend the timeframe.

[~~I.~~] H. The [~~MCO~~] MCO/SE shall provide the member and/or the member's representative a reasonable opportunity to present evidence[~~, and allegations~~] of the [~~fact~~] facts or law, in person as well as in writing.

[~~J.~~] I. The [~~MCO~~] MCO/SE shall provide the member and/or the representative the opportunity, before and during the appeals process, to examine the member's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the appeals process. The [~~MCO~~] 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.

[~~K.~~] J. For all appeals, the [~~MCO~~] MCO/SE shall provide written notice within the [~~thirty~~] 30-calendar-day timeframe [~~of the appeal resolution~~] for resolutions to the member or the provider, if the provider filed the appeal.

(1) The written notice of the appeal resolution shall include, but not be limited to, the following information:

(a) the [~~result(s)~~] results of the appeal resolution; and

(b) the date it was completed.

(2) The written notice of the appeal resolution for appeals not resolved wholly in favor of the member [~~must~~] 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 [~~those~~] continuing benefits if the hearing decision upholds the [~~MCO's~~] MCO's/SE's action.

[~~L.~~] K. The [~~MCO~~] MCO/SE may continue benefits while the appeal and/or the HSD fair hearing process is pending.

(1) The [~~MCO must~~] MCO/SE shall continue the member's benefits if all of the following are met:

(a) the member or the provider files a timely appeal of the [~~MCO~~] MCO/SE action (within 10 days of the date [~~the MCO mails the notice of action~~] on the notice of action from the MCO/SE);

(b) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(c) the services were ordered by an authorized provider;

(d) the time period covered by the original authorization has not expired; and

(e) the member requests extension of the benefits.

(2) The [~~MCO~~] MCO/SE shall provide benefits until one of the following occurs:

(a) the member withdraws the appeal;

(b) ten days have passed since the date the [~~MCO mailed~~] of the resolution letter, [~~providing~~] 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;

(d) the time period or service limits of a previously authorized service has expired.

(3) If the final resolution of the appeal is adverse to the member, that is, the [~~MCO~~] MCO's/SE's action is upheld, the [~~MCO~~] 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 [~~Section~~] 431.230(b).

(4) If the [~~MCO~~] MCO/SE or HSD reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending, the [~~MCO must~~] MCO/SE shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

(5) If the [~~MCO~~] MCO/SE or HSD reverses a decision to deny, limit or delay services and the member received the disputed services while the appeal was pending, the [~~MCO must~~] MCO/SE shall pay for these services.

[8.305.12.12 NMAC - Rp 8.305.12.12 NMAC, 7-1-04; A. 7-1-05]

8.305.12.13 EXPEDITED RESOLUTION OF APPEALS: An expedited resolution of an appeal is an expedited review by the [~~MCO~~] MCO/SE of an [~~MCO~~] MCO/SE action.

A. The [~~MCO~~] MCO/SE shall establish and maintain an expedited review process for appeals when the [~~MCO~~] MCO/SE determines that [~~taking~~] 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 provider's support of the member's request;

(3) a provider's request on behalf of the member; or

(4) the [~~MCO~~] MCO's/SE's independent determination.

B. The [~~MCO~~] MCO/SE shall ensure that the expedited review process is convenient and efficient for the member.

C. The [~~MCO~~] MCO/SE shall resolve the appeal within three (3) working days of receipt of the request for an expedited appeal, if the request meets the definition of expedited in Subsection A of 8.305.12.13 NMAC.

D. The [~~MCO~~] MCO/SE may extend the timeframe by up to 14 calendar days if the member requests the extension, or the [~~MCO~~] MCO/SE demonstrates to HSD that there is need for additional information and the extension is in the member's interest. For any extension not requested by the member, the [~~MCO~~] MCO/SE shall give the member written notice of the reason for the delay.

E. The [~~MCO~~] MCO/SE shall ensure that punitive action is not taken against a member or a provider who requests an expedited resolution or supports a member's expedited appeal.

F. The [~~MCO~~] 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 provider on behalf of the member.

G. The [~~MCO~~] MCO/SE shall inform the member of the limited time available to present evidence and allegations in fact or law.

H. If the [~~MCO~~] MCO/SE denies a request for an expedited resolution of an appeal, it shall:

(1) transfer the appeal to the thirty (30)-day timeframe for standard resolution, in which the 30-day period begins on the date the [~~MCO~~] MCO/SE received the original request for appeal;

(2) make reasonable efforts to give the member prompt oral notice of the denial, and follow up with a written notice within two (2) calendar days; and

(3) inform the member in the written notice of the right to file an appeal and/or request an HSD fair hearing if the member is dissatisfied with the [~~MCO's~~] MCO's/SE's decision to deny an expedited resolution.

I. The [~~MCO~~] MCO/SE shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.

[8.305.12.13 NMAC - Rp 8.305.12.12 NMAC, 7-1-04; A, 7-1-05]

8.305.12.14 SPECIAL RULE FOR CERTAIN EXPEDITED SERVICE AUTHORIZATION DECISIONS: In the case of expedited service authorization decisions that deny or limit services, the [~~MCO~~] MCO/SE shall, within 72 hours of receipt of the request for service, automatically file an appeal on behalf of the member, [~~make a~~] use its best effort, to give the member oral notice of the decision on the automatic appeal[~~, and make a best effort~~] and to resolve the appeal.

[8.305.12.14 NMAC - Rp 8.305.12.13 NMAC, 7-1-04; A, 7-1-05]

8.305.12.15 OTHER RELATED MCO PROCESSES:

A. **Information about grievance system to providers and subcontractors**: The [~~MCO must~~] MCO/SE shall provide information specified in 42 CFR [~~Section,~~] 438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.

B. **Grievance and/or appeal files:**

(1) All grievance and/or appeal files shall be maintained in a secure and designated area and be accessible to HSD , upon request, for review. Grievance and/or appeal files shall be retained for six (6) years following the final decision by the [~~MCO~~] MCO/SE, HSD, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later.

(2) The [~~MCO~~] MCO/SE shall have procedures for assuring that files contain sufficient information to identify the grievance and/or appeal, the date it was received, the nature of the grievance and/or appeal, notice to the member of receipt of the grievance and/or appeal, all correspondence between the [~~MCO~~] MCO/SE and the member, the date the grievance and/or appeal is resolved, the resolution, [~~and~~] 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.

[8.305.12.15 NMAC - Rp 8.305.12.15 NMAC, 7-1-04; A, 7-1-05]

8.305.12.16 [~~MCO PROVIDER GRIEVANCE~~] MCO/SE PROVIDER APPEAL PROCESS: [~~An MCO~~] The MCO/SE shall establish and maintain written policies and procedures for the filing of provider [~~grievances~~] appeals. A provider shall have the right to file [~~a grievance with the MCO regarding utilization management decisions and/or~~] an appeal with the MCO/SE regarding provider payment issues. [~~Grievances~~] Appeals shall be resolved within 30 calendar days. A 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. See 8.305.12.13 NMAC for special rules for certain expedited service authorizations.

[8.305.12.16 NMAC - Rp 8.305.12.17 NMAC, 7-1-04; A, 7-1-05]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.13 NMAC, Sections 9 and 10, which will be effective on July 1, 2005. The Medical Assistance Division amended the sections for the purpose of incorporating program changes related to the transitioning of the delivery of Medicaid behavioral health services from the managed care organizations to a single statewide entity (SE).

8.305.13.9 FRAUD AND ABUSE: HSD is committed to the development and implementation of an aggressive prevention, detection, monitoring and investigation program to reduce [~~provider and client~~] provider/member fraud and abuse and [~~client~~] 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 [~~MCO~~] MCO/SE shall comply with provisions of state and federal fraud and abuse laws and regulations.
[8.305.13.9 NMAC - Rp 8 NMAC 4.MAD.606.12, 7-1-01; A, 7-1-05]

8.305.13.10 MANAGED CARE ORGANIZATION AND SINGLE STATEWIDE ENTITY REQUIREMENTS: [~~The MCO shall maintain policies and procedures that address the prevention, detection and reporting of potential or actual Medicaid fraud and abuse cases. The policies and procedures shall be submitted to HSD for approval. Substantive amendments or modifications to policies and procedures shall be approved by HSD. The MCO shall maintain procedures for reporting potential and actual fraud and abuse by clients or providers to HSD.~~] The MCO/SE shall have in place internal controls, policies and procedures for the prevention, detection, investigation and reporting of potential fraud and abuse activities concerning providers and members. The MCO/SE specific internal controls, policies and procedures shall be described in a comprehensive written plan submitted to HSD, or its designee, for approval. Substantive amendments or modifications to the plan shall be approved by HSD. The MCO shall maintain procedures for reporting potential and actual fraud and abuse by clients or providers to HSD.

A. internal procedures that facilitate preliminary investigating and reporting of potential and actual fraud and abuse to HSD, or its designee, for further investigation;

B. a description of the specific controls in place for prevention and detection of potential cases of fraud and abuse, such as claims edits, post processing review of claims, provider profiling and credentialing prior authorizations, utilization/quality management monitoring;

C. a mechanism to work with HSD, or its designee, to further develop prevention and detection methods and best practices and to monitor outcomes for medicaid managed care;

D. internal procedures to prevent, detect and investigate program violations to help recover funds misspent due to fraudulent actions; and

E. a report to HSD of the names of all providers identified with aberrant utilization, according to provider profiles, regardless of the cause of the aberrancy.

[8.305.13.10 NMAC - Rp 8 NMAC 4.MAD.606.12.1, 7-1-01; A, 7-1-05]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.14 NMAC, Sections 9 through 13, which will be effective on July 1, 2005. The Medical Assistance Division amended the sections for the purpose of incorporating program changes related to the transitioning of the delivery of Medicaid behavioral health services from the managed care organizations to a single statewide entity (SE).

8.305.14.9 REPORTING REQUIREMENTS: The [~~MCO~~] MCO/SE shall provide to HSD managerial, financial, delegation, suspicious activity, utilization and quality reports. The content, format and schedule for submission shall be determined by HSD. HSD may require the [~~MCO~~] MCO/SE to prepare and submit ad hoc reports.
[8.305.14.9 NMAC - Rp 8 NMAC 4.MAD.606.13, 7-1-01; A, 7-1-05]

8.305.14.10 REPORTING STANDARDS:

A. Reports submitted by the [~~MCO~~] MCO/SE to HSD shall meet certain standards.

(1) The [~~MCO~~] MCO/SE shall verify the accuracy of data and other information on reports submitted [~~to HSD~~].

(2) Reports or other required data shall be received on or before scheduled due dates.

(3) Reports or other required data shall conform [~~with HSD~~] to HSD's defined standards.

(4) All required information shall be fully disclosed in a manner that is responsive and with no material omission.

(5) The [~~MCO~~] MCO/SE shall analyze all required reports internally before submitting them to HSD. The [~~MCO~~] MCO/SE shall analyze the report for any early patterns of change, identified trend, or outlier (catastrophic case), and shall submit this analysis with the required report. The [~~MCO~~] MCO/SE shall send a written narrative with the report documenting the [~~MCO's~~] MCO's/SE's interpretation of the early pattern of change, identified trend, or outlier.

B. **Consequences of violation of reporting standards:** The submission of late, inaccurate or otherwise incomplete reports shall be considered failure to report. Sanctions may be imposed by HSD, or its designee on the [~~MCO~~] MCO/SE for failure to submit accurate and timely reports.

C. **Changes in requirements:** [~~HSD~~] HSD's requirements regarding reports, report content and frequency of submission may change during the term of the [~~managed care~~] contract. The [~~MCO~~] MCO/SE shall comply with changes specified by HSD.
[8.305.14.10 NMAC - Rp 8 NMAC 4.MAD.606.13.1, 7-1-01; A, 7-1-04; A, 7-1-05]

8.305.14.11 MANAGERIAL REPORTS: Managerial reports demonstrate compliance with operational requirements of the [~~managed care~~] contract. These reports shall include, but not be limited to, information on such topics as:

A. MCO/SE: composition of current provider networks and capacity to take new medicaid [~~clients~~] members;

B. MCO/SE: changes in the composition and capacity of provider networks;

C. MCO: PCP-to-member ratios;

D. MCO/SE: identification of third-party liability;

E. MCO/SE: grievance resolution activity;

F. MCO/SE: fraud and abuse detection activities;

G. MCO/SE: delegation oversight activities; and

H. MCO/SE: member satisfaction.

[8.305.14.11 NMAC - Rp 8 NMAC 4.MAD.606.13.2, 7-1-01; A, 7-1-05]

8.305.14.12 FINANCIAL REPORTS: Financial reports demonstrate the [~~MCO's~~] MCO's/SE's ability to meet its commitments under the terms of the [~~managed care~~] contract. The format, content and frequency for submitting financial reports shall be determined by HSD. The [~~MCO~~] MCO/SE shall meet the following general requirements:

A. The 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 [~~Salud!~~] managed care physical health revenues and expenses [~~including a breakout of the Salud! behavioral health revenue 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 managed care behavioral health revenues and expenses. The result of the [~~MCO's~~] MCO's/SE's annual audit and related management letters shall be submitted no later than 150 days following the close of the [~~MCO's~~] MCO's/SE's fiscal year. The audit shall be performed by an independent certified public accountant. The [~~MCO~~] MCO/SE shall

submit for examination any financial reports requested by HSD.

B. The [~~MCO and its~~] MCO/SE and their subcontractors shall maintain their accounting systems in accordance with statutory accounting principles, generally accepted accounting principles, or other generally accepted system of accounting. The accounting system shall clearly document all financial transactions between the [~~MCO~~] MCO/SE and its subcontractors and the [~~MCO~~] MCO/SE and HSD. These transactions shall include, but not be limited to, claim payments, refunds and adjustment of payments.

C. The [~~MCO~~] MCO/SE and their subcontractors shall make available to HSD, and other authorized state or federal [~~agency~~] agencies, all financial records required to examine compliance by the [~~MCO~~] MCO/SE, in so far as those records are related to [~~MCO~~] MCO/SE performance under the [~~Salud!~~] contract. The [~~MCO and its~~] MCO/SE and their subcontractors shall provide HSD access to its facilities for the purpose of examining, reviewing and inspecting the [~~MCO's~~] MCO's/SE's records.

D. The [~~MCO and its~~] MCO/SE and their subcontractors shall retain all records and reports relating to agreements with HSD for a minimum of six years after the date of final payment. In cases involving incomplete audits and unresolved audit findings, administrative sanctions or litigation, the minimum six year retention period shall begin on the date such actions are resolved.

E. The [~~MCO~~] MCO/SE is mandated to notify HSD immediately when any change in ownership is anticipated. The [~~MCO~~] MCO/SE shall submit a detailed work plan [~~within 30 days of approval of the sale by the department of insurance~~] to the department of insurance during the transition period no later than the date of the sale, that identifies areas of the contract that [~~will~~] may be impacted by the change in ownership, including management and staff. The [~~MCO~~] MCO/SE shall submit records involving any business restructuring when changes in ownership interest in the [~~MCO~~] MCO/SE of 5% or more have occurred. These records shall include, but shall not be limited to, an updated list of names and addresses of all persons or entities having ownership interest in the [~~MCO of 5%~~] MCO/SE of five percent (5%) or more. These records shall be provided no later than 60 days following the change in ownership.

[8.305.14.12 NMAC - Rp 8 NMAC 4.MAD.606.13.3, 7-1-01; A, 7-1-04; A, 7-1-05]

8.305.14.13 UTILIZATION AND QUALITY MANAGEMENT REPORTING: Utilization and quality management reports demonstrate compliance with HSD's service delivery and quality standards. These reports shall include, but not be limited to:

A. [~~a monthly report~~] regular reporting that describes critical incidents as specified by HSD. For this purpose, critical incidents contribute to a trend that impacts negatively on areas such as quality of care, access to care or service delivery as defined by HSD;

B. regular reporting of encounter data as specified by HSD; [~~and~~]

C. regular reporting of utilization management activity; and

D. other required reports as determined by HSD, including, but not limited to, performance and tracking measures.

[8.305.14.13 NMAC - Rp 8 NMAC 4.MAD.606.13.4, 7-1-01; A, 7-1-05]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.15 NMAC, Sections 9, 10, 12, 13, 14, 15, 16, 18 through 21, which will be effective on July 1, 2005. The Medical Assistance Division amended the sections for the purpose of incorporating program changes related to the transitioning of the delivery of Medicaid behavioral health services from the managed care organizations to a single statewide entity (SE).

8.305.15.9 SERVICES FOR INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS (ISHCN):

A. ISHCN require a broad range of primary, specialized medical, behavioral health and related services. ISHCN are individuals who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition, or low to severe functional limitation, and who also require health and related services of a type or amount beyond that required by other individuals. ISHCN have ongoing health conditions, high or complex service utilization, and low to severe functional limitations. The primary purpose of the definition is to identify these individuals so that the [~~MCO~~] MCO/SE can facilitate access to appropriate services. The definition also allows for flexible targeting of individuals based on clinical justification and discontinuing targeted efforts when such efforts are no longer needed.

B. **Identification of enrolled ISHCN:** The [~~MCO~~] MCO/SE shall have written policies and procedures in place with [~~HSD~~] HSD's approval, which govern how members with multiple and complex physical and behavioral health care needs shall be identified. The [~~MCOs~~] MCO/SE shall have an internal operational process, in accordance with policy and procedure, to target members for the purpose of applying stratification criteria to identify ISHCNs. The [~~MCO~~] MCO/SE shall employ reasonable effort to identify ISHCNs based at least on the following criteria:

(1) individuals eligible for SSI;

(2) individuals enrolled in the home-based waiver programs;

(3) children receiving foster care or adoption assistance support;

(4) individuals identified by service utilization, clinical assessment, or diagnosis; and

(5) referral by family or a public or community program.

[8.305.15.9 NMAC - Rp 8.305.15.9 NMAC, 7-1-04; A, 7-1-05]

8.305.15.10 [~~SALUD!~~] MANAGED CARE ENROLLMENT FOR ISHCN:

A. **Switch enrollment:** Members, including ISHCN, may request to break a lock-in and be switched to membership in another MCO, based on cause. The member, the member's family or legal guardian shall contact HSD to request that the member be switched to another MCO. The MCO shall have policies and procedures to facilitate a smooth transition of a member who switches enrollment to another MCO. See Subsection F of 8.305.5.9 NMAC, *Member Switch Enrollment*.

B. **ISHCN information and education:**

(1) The [~~MCO~~] MCO/SE shall develop and distribute to ISHCN members, caregivers, parents and/or legal guardians, as appropriate, information and materials specific to the needs of this population. This includes information, such as items and services that are provided or not provided by the [~~Salud!~~] managed care program, information about how to arrange transportation, and which services require a referral from the PCP. The individual, family, caregiver, or legal guardian shall be informed on how to present an individual for care in an emergency room that is unfamiliar with the individual's special health care needs and about the availability of care coordination. See 8.305.9 NMAC, *Coordination of Services*. This information may be included either in a special member handbook or in an ISHCN insert to the MCO/SE member handbook.

(2) The [~~MCO~~] MCO/SE shall provide health education information to assist an ISCHN and/or caregivers in under-

standing how to cope with the day-to-day stress caused by chronic illness, including chronic behavioral health conditions.

(3) The [~~MCO~~] MCO/SE shall provide ISHCNs and/or caregivers a list of key [~~MCO~~] MCO/SE resource people and their telephone numbers. The [~~MCO~~] MCO/SE shall designate a single point of contact that an ISHCN, family member, caregiver, or provider may call for information.

[8.305.15.10 NMAC - Rp 8.305.15.10 NMAC, 7-1-04; A, 7-1-05]

8.305.15.12 SPECIALTY PROVIDERS FOR (ISHCN): The [~~MCO~~] MCO/SE shall have policies and procedures in place to allow direct access to necessary specialty care, consistent with [~~Salud!~~] managed care access appointment standards for clinical urgency, including behavioral health access standards. See 8.305.8.18 NMAC, S*tandards for Access*.

[8.305.15.12 NMAC - Rp 8.305.15.12 NMAC, 7-1-04; A, 7-1-05]

8.305.15.13 TRANSPORTATION FOR (ISHCN): The 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; [~~and~~]

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 transportation needs of its population with the member's respective MCO.

[8.305.15.13 NMAC - Rp 8.305.15.13 NMAC, 7-1-04; A, 7-1-05]

8.305.15.14 CARE COORDINATION FOR ISHCN: The [~~MCO~~s] MCOs/SE shall develop policies and procedures to provide care coordination for ISHCN. Please refer to Section 8.305.9.9 NMAC, *Coordination of Services*, for definition.

A. The [~~MCO~~] MCO/SE shall have an internal operational process, in accordance with policy and procedure, to target medicaid members for purposes of applying stratification criteria to identify those who are potential ISHCN. The contractor [~~will~~] shall provide HSD with the applicable policy and procedure describing the targeting and stratification process.

B. The [~~MCO~~] MCO/SE shall have written policies and procedures to ensure that each member identified as having special health care needs is assessed by an appropriate health care professional regarding the need for care coordination. If the member has both physical and behavioral health special needs, the MCO and SE shall coordinate care in a timely collaborative manner.

C. The [~~MCO~~] MCO/SE shall have written policies and procedures for educating ISHCN needs and, in the case of children with special health care needs, parent(s), legal guardians, that care coordination is available and when it may be appropriate to their needs.

[8.305.15.14 NMAC - Rp 8.305.15.14 NMAC, 7-1-04; A, 7-1-05]

8.305.15.15 EMERGENCY, INPATIENT AND OUTPATIENT AMBULATORY SURGERY HOSPITAL REQUIREMENTS FOR ISHCN: The [~~MCO~~] MCO/SE shall develop and implement policies and procedures for:

A. educating the ISHCN, the ISHCN's family members and/or caregivers concerning the ISHCNs with complicated clinical histories on how to access emergency room care and what clinical history to provide when emergency care or inpatient admission is needed, including behavioral health emergency care;

B. how coordination with the PCP, the SE (if applicable) and the hospitalist shall occur when an ISHCN is hospitalized;

C. ensuring that the emergency room physician has access to the individual's medical and/or behavioral health clinical history; and

D. obtaining any necessary referrals from PCPs for inpatient hospital staff providing outpatient or ambulatory surgical procedures.

[8.305.15.15 NMAC - Rp 8.305.15.15 NMAC, 7-1-04; A, 7-1-05]

8.305.15.16 REHABILITATION THERAPY SERVICES (PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY) FOR ISHCN: The MCO shall:

A. develop and implement therapy 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 and/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 providers in identifying issues to be included in the plan of care; and

D. develop and implement utilization prior [~~approval~~] authorization and continued stay criteria, including time frames, that are appropriate to the chronicity of the member's status and anticipated development process.

[8.305.15.16 NMAC - Rp 8.305.15.16 NMAC, 7-1-04; A, 7-1-05]

8.305.15.18 CLINICAL PRACTICE GUIDELINES FOR PROVISION OF CARE TO (ISHCN): The [~~MCO~~] 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 [~~medical~~] physical and behavioral health care services to this population. The guidelines should be based on professionally accepted standards of practice and national guidelines.

[8.305.15.18 NMAC - Rp 8.305.15.18 NMAC, 7-1-04; A, 7-1-05]

8.305.15.19 UTILIZATION MANAGEMENT (UM) FOR SERVICES TO (ISHCN): The [~~MCO~~] MCO/SE shall develop written policies and procedures to exclude from prior authorization any item of service identified in the course of treatment and/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.

[8.305.15.19 NMAC - Rp 8.305.15.19 NMAC, 7-1-04; A, 7-1-05]

8.305.15.20 ADDITIONS TO CONSUMER ASSESSMENT OF HEALTH PLANS SURVEY (CAHPS) FOR (ISHCN): [~~The MCO~~] An MCO/SE shall add questions about ISHCN to the most current HEDIS CAHPS survey.

[8.305.15.20 NMAC - Rp 8.305.15.20

NMAC, 7-1-04; A, 7-1-05]

8.305.15.21 ISHCN PERFORMANCE MEASURES: The [~~MCO~~] MCO/SE shall initiate a performance measure specific to ISHCN. See 8.305.8 NMAC, *Quality Management*.
[8.305.15.21 NMAC - Rp 8.305.15.21 NMAC, 7-1-04; A, 7-1-05]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.305.16 NMAC, Section 9 which will be effective on July 1, 2005. The Medical Assistance Division amended the sections for the purpose of incorporating program changes related to the transitioning of the delivery of Medicaid behavioral health services from the managed care organizations to a single statewide entity (SE).

8.305.16.9 [~~CLIENT~~] MEMBER TRANSITION OF CARE: The [~~MCO~~] MCO/SE shall actively assist with transition of care issues. Medicaid-eligible clients may initially receive [~~medical~~] physical and behavioral health services under fee-for-service medicaid prior to enrollment in managed care. During the member's medicaid eligibility period, enrollment status with a particular MCO may change and the member may switch enrollment to a different MCO. Certain members covered under managed care may become exempt and other members may lose their medicaid eligibility while enrolled in an [~~MCO~~] MCO/SE. A member changing from MCO to MCO, fee-for-service to managed care coverage and vice versa shall continue to receive medically necessary services in an uninterrupted manner. The [~~MCO~~] MCO/SE shall have the resources and policies and procedures in place to ensure continuity of care without disruption in service to members and to assure the service provider of payment.

A. **Member transition:** The [~~MCO~~] MCO/SE shall have policies and procedures that address member identification and the clinical transition and transfer of members into or out of the MCO.

(1) The MCO shall have policies and procedures that cover potentially large or mass transfer of members into or out of the MCO, including the identification of members currently receiving services, and the SE shall be notified.

(2) The MCO shall have policies and procedures covering the transition into the MCO of an individual member, which shall include member and provider education about the MCO and the review and update of existing courses of treatment. The SE shall be notified and coordination of care shall occur.

(3) The MCO shall have policies and procedures that identify members transferring out of the MCO and ensure the provision of member data and clinical information to the future MCO necessary to avoid delays in member treatment. The MCO shall have written policies and procedures to facilitate a smooth transition of a member to another MCO and/or SE, when a member chooses and is approved to switch to another MCO.

(4) The [~~MCO~~] MCO/SE shall have policies and procedures regarding provider responsibility for discharge planning upon the member's discharge from an inpatient or residential treatment facility, and the [~~MCO~~] 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 [~~MCO~~] MCO/SE shall honor all prior approvals granted by HSD through its contractors for the first 30 days of enrollment or until the [~~MCO~~] MCO/SE has made other arrangements for the transition of services. Providers who delivered services approved by HSD through its contractors shall be reimbursed by the [~~MCO~~] MCO/SE.

(2) For members who recently became exempt from [~~Salud!~~] managed care, HSD shall honor prior [~~approval~~] authorization of fee-for-service covered benefits granted by the [~~MCO~~] MCO/SE for the first 30 days under fee-for-service medicaid or until other arrangements for the transition of services have been made. Providers who deliver these services and are eligible and willing to enroll as medicaid fee-for-service providers shall be reimbursed by HSD.

(3) For members who had transplant services approved by HSD under fee-for-service, the MCO shall reimburse the 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 MCO, HSD shall reimburse the providers approved by the MCO if a donor organ becomes available for the member during the first 30 days under fee-for-service medicaid. Providers who deliver these services shall be eligible and willing to enroll as medicaid fee-for-service providers.

(5) For newly enrolled members, the [~~MCO~~] MCO/SE shall pay for prescriptions for drug refills for the first 30 days or until the [~~MCO~~] MCO/SE has made other arrangements. All drugs prescribed by a licensed behavioral health provider shall be paid for by the SE.

(6) For members who recently became exempt from [~~Salud!~~] managed care, HSD shall pay for prescriptions for drug refills for the first 30 days under the fee-for-service formulary. The pharmacy provider shall be eligible and willing to enroll as a medicaid fee-for-service provider.

(7) The MCO shall pay for DME costing $2,000 or more, approved by the MCO but delivered to the member after disenrollment from [~~Salud!~~] managed care.

(8) HSD shall pay for DME costing $2,000 or more, approved by HSD but delivered to the member after enrollment in the MCO. The DME provider shall be eligible for and willing to enroll as a medicaid fee-for-service provider. DME is not covered by the SE unless it has been prescribed by a behavioral health provider.

C. **Special payment requirement.** The MCO shall be responsible for payment of covered [~~medical services, including behavioral health care~~] physical health services, provided to the member for any month the MCO receives a capitation payment[~~, even if the member has lost medicaid eligibility~~]. The SE shall be responsible for payment of covered behavioral health services provided to the member for any month the SE receives a capitation payment.

D. **Claims processing and payment:** In the event that an [~~MCO's~~] MCO's/SE's contract with HSD or the collaborative has ended, is not renewed or is terminated, the [~~CONTRACTOR~~] MCO/SE shall remain responsible for processing and paying claims for services delivered through the contract period, but submitted after the [~~MCO's~~] MCO's/SE's contract has ended.

(1) The [~~MCO~~] MCO/SE shall be required to inform providers in writing, at least 30 days prior to the end of the contract, of the termination of the contract and of the process for providers to submit claims for services provided through the contract end date. The letter shall include the telephone, fax numbers, and the billing address for claims submissions as well as the names of persons to contact with questions.

(2) The [~~MCO~~] MCO/SE shall allow six months to process claims for services provided prior to the contract termination date.

(3) The [~~MCO~~] MCO/SE shall continue to meet timeframes established for processing all claims.
[8.305.16.9 NMAC - N, 7-1-01; A, 7-1-04; A, 7-1-05]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.324.4 NMAC, Sections 9, 10, 12, 15 and 16, which will be effective on July 1, 2005. The Medical Assistance Division amended sections 9, 12 and 15 to clarify that pharmacies need to submit claims to various pharmacy claims adjudicators subcontracted by entities designated by MAD. In sections 10 and 16, the term "physician" was changed to "practitioner" to accommodate other providers authorized to prescribe under state law.

8.324.4.9 PHARMACY SERVICES: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients, including covered pharmacy services [42 CFR Section 440.120(a)]. This section describes eligible pharmacy providers, covered services, service limitations, and general reimbursement methodology. Pharmacy claims must be submitted to the appropriate pharmacy claims processor as designated by the medical assistance division. The pharmacy claims processor may vary based on the prescriber's license, practice specialty, network affiliation and/or the client's category of eligibility or enrollment in a contracted health plan.
[8.324.4.9 NMAC - Rp, 8 NMAC 4.MAD.753, 8/13/04; A, 7/1/05]

8.324.4.10 ELIGIBLE PROVIDERS:

A. Upon MAD's approval of medical assistance program provider participation agreements, the following providers are eligible to furnish pharmacy services:

(1) pharmacies licensed by the New Mexico pharmacy board;

(2) clinics licensed for outpatient dispensing by the New Mexico pharmacy board;

(3) institutional pharmacies licensed for outpatient dispensing by the New Mexico pharmacy board;

(4) family planning clinics and rural health clinics licensed for outpatient dispensing by the New Mexico board of pharmacy;

(5) prescribing [~~physicians~~] practitioners practicing in communities more than fifteen (15) miles from a licensed pharmacy; and

(6) Indian health service (IHS), Indian Self-Determination and Education Assistance Act ("tribal 638") and IHS contract pharmacies and drug rooms operated consistent with IHS standards of practice for pharmaceutical care.

B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.
[8.324.4.10 NMAC - Rp, 8 NMAC 4.MAD.753.1, 8/13/04; A, 7/1/05]

8.324.4.12 COVERED SERVICES: MAD covers most medically necessary prescription drugs and some over-the-counter drugs, subject to the limitations and restrictions delineated in this Part. Claims for injectable drugs, intravenous (IV) admixtures, IV nutritional products and other expensive medications can be reviewed for medical necessity before or after reimbursement. Providers must consult MAD, or its designated contractor, before supplying items not specifically listed in this policy or billing instructions. Coverage of over-the-counter items is limited to situations where the over-the-counter items may be the drug of choice for common medical conditions and when the over-the-counter item provides an appropriate economical and therapeutic alternative to prescription drug items. Drug restrictions include dosage, day supply, and refill frequency limits necessary to ensure appropriate utilization or to prevent fraud and abuse. In establishing such limits, professional standards of health are considered.
[8.324.4.12 NMAC - Rp, 8 NMAC 4.MAD.753.3, 8/13/04; A, 7/1/05]

8.324.4.15 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing. Review or prior authorization may be required for items for which a lesser expensive or therapeutically preferred alternative should be used first. Establishing these therapeutic "step" requirements will be based on published clinical practice guidelines, professional standards of health care, and economic considerations.

A. **Prior authorization:** MAD, or its designated contractor, reviews all requests for prior [~~authorization on special drug requests~~] authorizations. The MAD utilization review (UR) contractor grants prior authorization on durable medical equipment and medical supplies which can be dispensed by pharmacy services providers. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior authorization of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. **Reconsideration:** Providers who disagree with prior authorization request denials or other review decisions can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953].

D. **Drug utilization review:** The MAD drug utilization review (DUR) program is designed to assess the proper utilization, quality, therapy, medical appropriateness and costs of prescribed medication through evaluation of claims data, as required by 42 CFR 456.700-716. The DUR program is done on a retrospective, prospective and concurrent basis. This program shall include, but is not limited to, data gathering and analysis and a mix of educational interventions related to over-utilization, under-utilization, therapeutic duplication, drug-to-disease and drug-to-drug interactions, incorrect drug dosage or duration of treatment and clinical abuse or misuse. Information collected in the DUR program that identifies individuals is confidential and may not be disclosed by the MAD DUR board to any persons other than those identified as the recipient's service providers or governmental entities legally authorized to receive such information.

(1) **Prospective drug use review:** Prospective DUR (ProDUR) is the screening for potential drug therapy problems (such as, over-utilization, under-utilization, incorrect drug dosage, therapeutic duplication, drug-disease contraindication, adverse interaction, incorrect duration of drug therapy, drug-allergy interations, clinical abuse or misuse) before each prescription is dispensed. The dispensing pharmacist is required to perform prospective drug use review prior to dispensing. Only a licensed pharmacist or intern may perform ProDUR activities. The pharmacist may be required to insert appropriate DUR override codes when the ProDUR system detects drug therapy issues. In retrospective review of paid claims, payment may be recouped for claims in which the pharmacist has not followed accepted standards of professional practice.

(2) **Counseling:** Pursuant to 42 CFR 456.705, each dispensing pharmacist must offer to counsel each medicaid recipi-

ent receiving benefits (or the caregiver of such individual) who presents a new prescription, unless the recipient refuses such counsel. Pharmacists must document these refusals. If no documentation of refusal of counseling is available or readily retrievable, it will be assumed that appropriate counseling and prospective drug use review has taken place. A reasonable effort must be made to record and maintain the pharmacist's comments relevant to said counseling and prospective drug review, particularly when ProDUR overrides are performed. Counseling must be done in person, whenever practicable. If it is not practicable to counsel in person, providers whose primary patient population do not have access to a local measured telephone service must provide access to a toll-free number.

[8.324.4.15 NMAC - Rp, 8 NMAC 4.MAD.753.7, 8/13/04; A, 7/1/05]

8.324.4.16 REIMBURSEMENT: Pharmacy providers must submit claims for reimbursement on the separate pharmacy claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services* and 8.324.4.17 NMAC, *Pharmacy Point of Sale*. Once enrolled, providers receive instructions on documentation, billing and claims processing.

A. **General reimbursement methodology:** MAD's total reimbursement for a prescription drug must not exceed the lowest of the estimated acquisition cost (EAC), the maximum allowable cost (MAC), the federal upper limit (FUL), or the usual and customary charge.

(1) **Estimated acquisition cost (EAC).** MAD determines EAC as follows:

(a) MAD establishes EAC, defined as MAD's approximation of the net or actual acquisition costs of such drugs to pharmacies in New Mexico for all covered drugs, following consultation with representatives of the New Mexico pharmacy profession. Dispensing fees are in addition to EAC.

(b) The factors MAD considers in setting rates for drugs under this subparagraph include:

(i) product cost, which may vary among purchasing contracts;

(ii) MAD's documented clinical concerns;

(iii) MAD's budget limits; and

(iv) the actual package size dispensed.

(c) MAD uses the EAC as MAD's reimbursement for a drug when the EAC, plus a dispensing fee established by MAD, is the lowest of the rates calculated under the methods listed in general reimbursement methodology, Subsection A of 8.324.4.16 NMAC.

(d) EAC cannot exceed the lowest of the current published average wholesale price of a drug less a percentage established by the department or EAC, determined by reference to other pricing information sources selected by MAD pursuant to general reimbursement methodology, Subsection A of 8.324.4.16 NMAC.

(2) **Maximum allowable cost (MAC); MAC methodology.** MAD establishes a maximum allowable cost (MAC) applicable for certain multiple-source drugs with FDA rated therapeutic equivalents and certain over-the-counter drugs and non-drug items on the following basis:

(a) at least one A-rated generic (as listed in the FDA orange book) is readily available to New Mexico pharmacies;

(b) the state MAC for the brand name drug products and for all A-rated therapeutic equivalents shall be determined by taking the lowest available cost for all of the A-rated therapeutic equivalent drugs regardless of manufacturer, and multiplying that by cost a factor set by MAD to cover the pharmacy's estimated administration and overhead plus a dispensing fee;

(c) the state MAC list will be updated at least quarterly, with on-going adjustments due to pricing changes and availability issues;

(d) all products on the state MAC list will be reviewed at a minimum every 6 months;

(e) if a "federal upper limit" (FUL) has been set for a product, then the MAC will not be applied if the FUL ingredient reimbursement rate is lower than the MAC reimbursement rate;

(f) MAC will not be applied if the calculation equals an amount greater than the current EAC, as defined in estimated acquisition costs in Paragraph (1) of Subsection A of 8.324.4.16 NMAC;

(g) MAC will not be applied if a specific brand has been determined to be medically necessary, in which event the reimbursement rate will be the EAC of the product dispensed plus the dispensing fee;

(h) for over-the-counter drugs and non-drug items, MAC may be established using the pricing sources in Subsection B of 8.324.16 NMAC.

(3) **Federal upper limit (FUL) methodology:**

(a) MAD adopts the FUL that is set by the centers for medicare and medicaid services (CMS).

(b) MAD's maximum payment for multiple-source drugs for which CMS has set FULs will not exceed, in the aggregate, the prescribed upper limits plus the dispensing fees set by MAD under the dispensing fee determination.

(c) Except as provided in MAC methodology and in subparagraph (4) below, MAD uses the FUL as MAD's reimbursement rate for all FDA A-rated, therapeutic-equivalent drugs when the FUL price, plus a dispensing fee, is the lowest of the rates calculated under the methods listed in general reimbursement methodology, Subsection A of 8.324.4.16 NMAC.

(d) MAD will not use the individual drug FUL as MAD's reimbursement rate when the prescribing [~~physician~~] practitioner has certified that a specific brand is medically necessary, in which event the reimbursement rate will be the EAC of the product dispensed plus the dispensing fee.

(4) **Usual and customary charge:**

(a) The provider's billed charge must be its usual and customary charge for services. Over-the-counter items must be billed with the over-the-counter price as the usual and customary charge, unless it is labeled and dispensed as a prescription.

(b) "Usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific procedure or service.

(c) Usual and customary charges must reflect discounts given to non-medicaid recipients for certain reasons, such as age or nursing home residents, when a medicaid recipient meets the standards for the discount. Medicaid must be given the advantage of discounts received by the general public, including promotions or items sold at cost to the general public, if these are the prices usually and customarily charged to non-medicaid recipients.

(d) Providers must not add additional costs for their time, paperwork, or anticipated turnaround time for payment.

(5) **340B drug discount:** Drugs purchased under section 340B of the Public Health Service Act, 42 USC 256b, and dispensed to medicaid recipients will be reimbursed at established rates, after consultation with representatives of the New Mexico pharmacy profession.

(6) **Medicare reimbursement:** Reimbursement may be limited to medicare reimbursement limits where the total of the medicare-allowed amounts plus, if applicable, a dispensing fee, is the lowest of EAC, MAC, FUL, usual and customary charge or 340B drug discount amount as defined in Subsection A of 8.324.16 NMAC, *Reimbursement*.

B. **Pricing information to set EAC and MAC:** MAD selects the sources for pricing information used to set EAC and MAC. These sources may include pharmaceutical wholesalers, manufacturers, drug data information clearinghouses (e.g., first data bank) and pharmacy invoices.

C. **Assistance in establishing EAC and MAC:** MAD may solicit assistance from pharmacy providers, pharmacy benefit managers (PBMs), other government agencies, actuaries, and/or

other consultants when establishing EAC and/or MAC.

D. **Pharmacy provider reductions:** If the pharmacy provider offers a discount, rebate, promotion or other incentive that directly relates to the reduction of the price of a prescription to the individual non-medicaid customer, the provider must similarly reduce its charge to MAD for the prescription.

E. **No claims for free products:** If a pharmacy gives a product free to the general public, the pharmacy must not submit a claim to MAD when giving the free product to a medicaid recipient.

F. **Solutions:** Solutions, such as saline for nebulizers, intravenous (IV) solutions without additives, irrigation solutions, and diluents are considered medical supply items for reimbursement purposes. See 8.350.3 NMAC, *Durable Medical Equipment and Medical Supplies* [MAD-754].

G. **Non-drug items:** Urine test reagents, nutritional products, equipment and medical supplies, including syringes and alcohol swabs, are subject to restrictions for medical supplies. See 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies* [MAD-754].

(1) When a pharmacy does not provide the ongoing clinical monitoring and care coordination involved with an episode of home infusion therapy, the NCPDP claim format must be used for billing the involved drugs. If the pharmacy's business includes providing ongoing clinical monitoring and care coordination related to an episode of home infusion therapy, the drugs must be billed in CMS-1500 or ASC X12N 837 format, or as otherwise consistent with federally required national standards. When an order for infusion therapy includes medical supply items that do not have NDC numbers assigned to them by the manufacturer, repackager or labeler, those items must be billed in the CMS-1500 or ASC X12N 837 format, or as otherwise consistent with federally required national standards.

(2) Reimbursement is calculated for the medical supply portion according to medical supply regulations and for the drug portion under these regulations.

[8.324.4.16 NMAC - Rp, 8 NMAC 4.MAD.753.8, 8/13/04; A, 7/1/05]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.324.8 NMAC, Sections 5, 12 and 13, which will be effective on July 1, 2005. The Medical Assistance Division amended the sections to clarify that medically necessary therapeutic shoes and inserts furnished to diabetics are reimbursable items to Medicaid providers.

8.324.8.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.

[2/1/95; 8.324.8.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 7/1/04; A, 7/1/05]

8.324.8.12 COVERED SERVICES AND SERVICE LIMITATIONS: Medicaid covers medically necessary prosthetics and orthotics supplied by providers only when specified requirements or conditions are satisfied. Prosthetic devices are replacements or substitutes for a body part or organ, such as an artificial limb or an eye prosthesis. Orthotic devices support or brace the body, such as trusses, compression custom-fabricated stockings and braces. **Conditions of coverage:** Medicaid covers prosthetics and orthotics only when all the following conditions are met:

A. the device has been ordered by a physician or other licensed practitioner and is medically necessary for recipient mobility, support or physical functioning;

B. the need for the device is not satisfied by the existing device the recipient currently has; [~~and~~]

C. the device is covered by medicaid and any required prior approval requirements have been satisfied;

D. coverage of compression stockings for adults is limited to stockings that are custom-fabricated to meet the recipient's medical needs;

E. coverage of orthopedic shoes for adults is limited to the shoe that is attached to a leg brace;

F. replacement of items is limited to one item every three years, unless there are changes in medical necessity; and

G. therapeutic shoes furnished to diabetics limited to one of the following within one calendar year:

(1) no more than one pair of custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts; and

(2) no more than one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes).

[2/1/95; 3/1/99; 8.324.8.12 NMAC - Rn, 8 NMAC 4.MAD.757.3 & A, 7/1/04; A, 7/1/05]

8.324.8.13 NONCOVERED SERVICES: Prosthetic and orthotic services are subject to the limitations and coverage restrictions that exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services* [MAD-602]. In addition to the services identified in 8.301.3 NMAC [MAD-602], *General Noncovered Services*, the following services are not covered:

A. orthotic supports for the arch or other supportive devices for the foot, unless they are integral parts of a leg brace or therapeutic shoes furnished to diabetics;

B. prosthetic devices or implants that are used primarily for cosmetic purposes.

[2/1/95; 3/1/99 8.324.8.13 NMAC - Rn, 8 NMAC 4.MAD.757.4 & A, 7/1/04; A, 7/1/05]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.352.2 NMAC, Sections 5, 7 and 11, which will be effective on July 1, 2005. The Medical Assistance Division amended the sections to add the definition for State Coverage Insurance (SCI) and to include it in the hearing process reference.

8.352.2.5 EFFECTIVE DATE: January 1, 2000, unless a later date is cited at the end of a section.

[11-1-96, 1-1-00; 8.352.2.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 7-1-01; A, 7-1-05]

8.352.2.7 DEFINITIONS:

A. "Action" means a termination, modification, reduction, or suspension of a covered service.

B. "Contractor" means a managed care organization (MCO), or HSD's utilization review contractor.

C. "Date of action" means the intended date on which a termination, modification, reduction, or suspension becomes effective.

D. "Denial" means the decision not to authorize a requested service.

E. "Hearing" or "administrative hearing" means an evidentiary hearing that is conducted so that evidence may be presented.

F. "HSD" means the human services department.

G. "MAD" means the medicaid assistance division.

H. "Notice" means a written statement that includes what action is being taken, the reasons for the intended action, the specific regulation that requires the action, and an explanation of the recipient's right to request a hearing, along with an explanation of the circumstances under which the service may be continued if a hearing is requested.

I. "Parties to the hearing" are the human services department (HSD)

and the recipient. If the hearing issue is an MCO action, the parties are HSD, the recipient, and the MCO.

J. "Request for hearing" means a clear expression by a recipient or an authorized representative that the recipient wants the opportunity to present his or her case to a reviewing authority.

K. "State coverage insurance" SCI- health insurance flexibility and accountability waiver program for coverage of uninsured adults.

[~~K.~~] L. "Utilization review contractor" is a contractor with the New Mexico medicaid program responsible for medical level of care reviews and medical necessity reviews for fee-for-service (not MCO) services.

[11-1-96, 1-1-00; 8.352.2.7 NMAC - Rn, 8 NMAC 4.MAD.970.1 & A, 7-1-01; A, 7-1-05]

8.352.2.11 HEARING PROCESS REFERENCE: HSD has established an administrative process for medicaid recipients who meet the criteria described above in 8.352.2.10 NMAC. For medicaid eligibility appeals procedures, See 8.100.970 NMAC, Fair Hearings. See 8.354.2 NMAC, Pasaar And Patient Status Hearings for policies on administrative hearings requests by residents who believe that a nursing facility determination that they be transferred or discharged is erroneous and for requests by any recipient who believes that the state determination with regard to the preadmission and annual resident review requirements is erroneous. 8.305.12 NMAC, Grievance Resolution describes appeal rights and processes for SALUD! enrolled recipients. A SALUD! enrolled recipient has a two-pronged appeals process available on issues of medical services: (1) through the HSD administrative hearings process described in this section, and (2) through the grievance resolution process described in 8.305.12 NMAC. The processes may be sequential or simultaneous. An SCI program participant may appeal eligibility denials and closures through the HSD administrative hearing process. SCI enrollment and benefits issues must be addressed through the managed care grievance/appeals process. If the benefit or enrollment issue is not resolved at the MCO grievance/appeal level, issues of MCO action may be taken to the HSD administrative hearing process. Issues of late premium payment or failure to pay the premium addressed through the MCO grievance/appeal process and not resolved at that level may be appealed to the state district court at the appellant's expense.

[11-1-96, 1-1-00; 8.352.2.11 NMAC - Rn, 8 NMAC 4.MAD.972, 7-1-01; A, 7-1-05]

NEW MEXICO PUBLIC EMPLOYEES RETIREMENT ASSOCIATION

This is an amendment to 2.80.100 NMAC, Section 7, effective June 30, 2005.

2.80.100.7 DEFINITIONS: As used in the Public Employees Retirement Act:

A. "Accumulated member contributions" means amounts deducted from the salary of a member and credited to the member's individual account, together with interest if any, credited to that account; it also includes repaid withdrawn contributions not including interest paid thereon, or amounts paid to purchase service credit as allowed under the PERA Act.

B. "Active duty" for purposes of acquiring service credit under NMSA 1978, Section 10-11-7, as amended, for periods of active duty with uniformed service of the United States, means full-time duty in the active uniformed service of the United States, including full-time training duty, annual training duty, and attendance while in the active military service, at a school designated as a service school by law or by the secretary of the military department concerned. "Active duty" does not include full-time national guard duty, which is training or other duty performed by a member of the air or army national guard of a state or territory, for which the member is entitled to pay from the United States or for which the member has waived pay from the United States. "Active duty" includes duty in the full-time military service reserve components activated pursuant to a federal call to duty, deployment for a peacekeeping mission or other declared national emergency.

C. "Adult correctional officer member" means a person who is an adult correctional officer or an adult correctional officer specialist employed by the corrections department or its successor agency.

D. "Another retirement program" means retirement plans established by the Judicial Retirement Act, Magistrate Retirement Act, and the Educational Retirement Act.

E. "Elected official" means a person elected to a public office by registered voters, who is paid a salary; "elected official" includes a person who is appointed to fill an unexpired term of an elected public office, who is paid a salary.

F. "Filed" means that PERA has received the complete document as evidenced by a writing on the document indicating the date of receipt by PERA.

G. "Fire member" means any member who is employed as a firefighter by an affiliated public employer, is paid a salary and has taken the oath prescribed for firefighters. The term shall not include volunteer firefighters or any civilian employees of a fire department.

H. "Hazardous duty member" means a juvenile or adult correctional officer employed by the children, youth and families department or its successor agency, but does not include any member who is a "police member" or a "fire member". A hazardous duty member shall, however, be considered a state policeman for federal Social Security Act purposes.

I. "Leave office" means an elected official's successor has been duly elected or appointed and qualified for office, or upon the date of death of an elected official.

J. "Legal representative" means "personal representative" as defined in the Probate Code of New Mexico which includes executor, administrator, successor personal representative, special administrator and persons who perform substantially the same functions under the law governing their status, or an attorney or a person acting pursuant to a power of attorney for a member, retired member or beneficiary.

K. "Municipal detention officer" means a member who is employed by an affiliated public employer other than the state who has inmate custodial responsibilities at a facility used for the confinement of persons charged or convicted of a violation of a law or ordinance. "Municipal detention officer" includes both juvenile and adult municipal detention officers.

L. "Permissive service credit" means service credit recognized by the retirement system for purposes of calculating a member's retirement benefit, which is available only by making a voluntary additional contribution which does not exceed the amount necessary to fund the benefit attributable to such service credit. A vested member may purchase a total of five (5) years of permissive service credit as permitted by the Internal Revenue Code Section 415(n)(3)(B) limitations on non-qualified service credit. "Permissive service credit" includes service eligible for purchase under NMSA 1978, Sections 10-11-7[~~and 10-11-8(H)~~], as amended.

M. "Police member" means any member who is employed as a police officer by an affiliated public employer, who is paid a salary, and who has taken the oath prescribed for police officers. The term shall not include volunteers, hazardous duty members, or employees who do not perform primarily police functions including, but not limited to jailers, cooks, matrons, radio operators, meter checkers, pound employees, crossing guards, police judges, park conservation officers, and

game wardens. A member who is employed by an affiliated public employer as a police officer and as a non-police officer employee shall be regarded as a police member if more than fifty percent of the member's total salary is paid as a police officer.

N. "Private retirement program" for the purpose of exclusion from membership under NMSA 1978, Section 10-11-3(B)(5) means a retirement program of the affiliated public employer which meets the internal revenue service minimum standards regarding benefits as outlined in 26 C.F.R. Section 31.3121(b) (7)F of the Employment Tax Regulations and IRS Rev. Proc. 91-40.

O. "Reenlistment" as used in NMSA 1978, Section 10-11-6(A)(3), means enlistment or voluntary entry into one of the armed services as either enlisted personnel or as a commissioned officer.

P. "Retired member" means a person who is being paid a normal, deferred or disability pension on account of that person's membership in the association. "Retired member" shall not include any persons receiving a pre-retirement survivor pension, post-retirement survivor pension, or reciprocity retirement pension where the payer system is not PERA, or any other person unless specifically included by definition as a "retired member".

Q. "Salary" means the base salary or wages paid a member, including longevity pay, for personal services rendered to an affiliated public employer. "Salary" includes a member's fixed, periodical compensation from full or part time employment; shift differentials; and wages paid while absent from work on account of vacation, holiday, injury or illness, which means payment made by continuing the member on the regular payroll. "Salary" includes incentive pay that is not temporary and becomes part of member's base salary. "Salary" also includes temporary promotions, temporary salary increases, but no other temporary differentials. "Salary" shall not include overtime pay, allowances for housing, clothing, equipment or travel, payments for unused sick leave, unless the unused sick leave payment is made through continuation of the member on the regular payroll for the period represented by that payment. "Salary" also does not include lump sum payments which are not part of the member's fixed periodical compensation, such as lump sum annual and sick leave or occasional payments to elected officials for attending meetings, allowances for any purpose, employer contributions to a private retirement program, or other fringe benefits, even if they are paid to or for a member on a regular basis, and any other form of remuneration not specifically designated by law as included in salary for Public Employees Retirement Act purposes.

R. "State legislator member" means a person who is currently serving or who has served as a state legislator or lieutenant governor and who has elected to participate in a state legislator member coverage plan. A former legislator or former lieutenant governor may be a "state legislator member" whether or not currently receiving a pension under a state legislator member coverage plan.

S. "State system" means a retirement program provided for in the Public Employees Retirement Act, Magistrate Retirement Act, or Judicial Retirement Act.

T. "Terminate employment" means that a member has a complete break in service and an absolute cessation of employment with all affiliated public employers, including employment as an elected official, as evidenced by a personnel action form or other equivalent document, and the member is not reemployed by an affiliated public employer for 30 days; or upon the date of death of a member.

[10-15-97; 11-15-97; 1-15-99; 12-15-99; 2.80.100.7 NMAC - Rn & A, 2 NMAC 80.100.7, 12-28-00; A, 12-28-01; A, 9-30-03; A, 6-30-05]

NEW MEXICO PUBLIC EMPLOYEES RETIREMENT ASSOCIATION

This is an amendment to 2.80.200 NMAC, Sections 60 and 70, effective June 30, 2005.

2.80.200.60 ELECTION OF RETIRED BOARD MEMBERS

A. During the January monthly meeting, the retirement board shall adopt a resolution specifying when nominating petitions are due to be returned to PERA. These nominating petitions are due not earlier than six months prior and not later than one month prior to the election for the position of retired board member.

B. Any retired member who is receiving a disability or normal retirement pension [~~from PERA~~] under the Public Employees Retirement Act, Judicial Retirement Act or the Magistrate Retirement Act is eligible for election to a retired board member position.

C. Nominating petitions shall be signed only by retired members [~~of the association~~] under the Public Employees Retirement Act, Judicial Retirement Act or the Magistrate Retirement Act. To be eligible, a candidate must have a minimum of 50 nominations. A valid nomination shall include a signature, a legible printing of the retiree's name, address and the last four digits of the retiree's social security number. A nomination that does not include all these elements shall not be counted. A retired member may sign more than one nominating petition for different candidates. The five candidates with the highest number of nominations shall be included on the ballot and the other or others shall be eliminated. The names of the five retired members receiving the highest number of nominations shall be placed on the election ballot in descending order according to the number of signatures received. In case of a nominating tie, the election committee shall determine the names and order in which they are placed on the ballot by lottery or similar method.

D. In the event any nominee is unable or unwilling to accept a nomination, that nominee's name shall be removed from the ballot and the resulting vacancy on the ballot shall not be filled. If the inability or unwillingness to accept a nomination occurs after the ballots have been printed the election committee shall treat all votes cast for that nominee as void.

E. If only one retiree is nominated for a retired board member position, the election shall be cancelled and that retiree shall automatically be declared the winner for the retired board member position pursuant to subsection 200.80.

F. Only retired members under the Public Employees Retirement Act, Judicial Retirement Act or the Magistrate Retirement Act shall be eligible to participate in the election of retired board members.

G. The campaign contribution limit of twenty-five dollars ($25.00) contained in NMSA 1978, Section 10-11-130.1(B)(2000) shall apply to each four year term retired board member election.

[10-15-97; 11-15-97; 12-15-99; 2.80.200.60 NMAC - Rn & A, 2 NMAC 80.200.60, 12-28-00; A, 8-15-01; A, 6-30-05]

2.80.200.70 ELECTION OF NON-RETIRED BOARD MEMBERS

A. During the January monthly meeting, the retirement board shall adopt a resolution specifying when nominating petitions are due to be returned to PERA. These nominating petitions are due not earlier than 6 months prior and not later than 1 month prior to the election for the position of non-retired board member.

(1) Candidates nominated for any non-retired board member position shall be vested members [~~of the association~~] under the Public Employees Retirement Act, Judicial Retirement Act or the Magistrate Retirement Act.

(2) Only state members, including members under the Judicial Retirement Act or the Magistrate Retirement Act, may nominate candidates for state board member positions. Only county members may nom-

inate candidates for the county board member position. Only non-county municipal members may nominate candidates for the remaining municipal board member positions.

(3) To be eligible, a candidate must have a minimum of 150 valid nominations of non-retired PERA members from the candidate's membership group on his or her nominating petition. A valid nomination shall include a signature, a legible printing of the member's name, the member's current employer and the last four digits of the member's social security number. A nomination that does not include all these elements shall not be counted. A member may sign more than one nominating petition for different candidates.

(4) The five candidates with the highest number of nominations for each non-retired position shall be included on the ballot and the other or others shall be eliminated. The names of the five non-retired members receiving the highest number of nominations for a position shall be placed on the election ballot in descending order according to the number of signatures received. In case of a nominating tie, the election committee shall determine the names and order in which they are placed on the ballot by lottery or similar method.

(5) In the event any nominee is unable or unwilling to accept the nomination, his or her name shall be removed from the ballot and the vacancy on the ballot shall not be filled. If such a vacancy occurs after the ballots have been printed, the election committee shall treat all votes cast for that candidate as void.

(6) If only one member is nominated for a non-retired board member position, the election shall be cancelled and that member shall automatically be declared the winner for the non-retired board member position pursuant to subsection 200.80.

(7) All members of record of the membership group for which the election is held shall be eligible to receive a ballot as provided in subparagraph 8(a) below, except that only county members shall vote in elections for the county member position, and shall not be eligible to vote in elections for non-county municipal positions. The applicable membership group for any member who is no longer a currently employed, contributing employee of an affiliated public employer shall be determined as of the last date on which the member was a currently employed, contributing employee of an affiliated public employer.

(8) For purposes of the election of non-retired board members, "member of record" shall mean the following:

(a) all persons listed in PERA electronic membership history records as members, including members covered under the Public Employees Retirement Act, Judicial Retirement Act or the Magistrate Retirement Act, no more than 60 days prior to the date of mailing ballots; or

(b) all persons who have filed with PERA a valid application for membership form 60 days or more prior to the date of mailing ballots.

(c) While members of record shall qualify to receive a ballot, in the case of those new members listed in subparagraph 70.A(8)(b), a written request for a ballot must be made to PERA.

(9) For purposes of the election of non-retired board members:

(a) ballots shall be mailed to all non-county municipal members of record in the case of an election of a non-county municipal board position;

(b) ballots shall be mailed to all county municipal members of record in the case of an election of the county municipal board position; and

(c) ballots shall be mailed to all state members of record in the case of an election of a state board position.

B. The campaign contribution limit of twenty-five dollars ($25.00) contained in NMSA 1978, Section 10-11-130.1(B)(2000) shall apply to each four year term non-retired board member election.

[10-15-97;11-15-97; 12-15-99; 2.80.200.70 NMAC - Rn & A, 2 NMAC 80.200.70, 12-28-00; A, 8-15-01; A, 6-30-05]

NEW MEXICO PUBLIC EMPLOYEES RETIREMENT ASSOCIATION

This is an amendment to 2.80.600 NMAC, Section 20, effective June 30, 2005.

2.80.600.20 SERVICE CREDIT

A. In order to claim service credit for service rendered prior to August 1, 1947 or for a period prior to the employer becoming an affiliated public employer, a member shall:

(1) file a claim for the period of employment showing specific beginning and ending dates of employment;

(2) provide certification of employment to the association for the period or periods claimed as prior service;

(3) file an affidavit, to be certified and signed by two other persons who know of the employment, together with any additional documentary evidence available which may be required by the board if no records are available for the period of prior service claimed;

(4) provide payroll records, personnel action forms showing hire date(s), term of employment, full-time or part-time, job classification, salary amounts and dates of personnel actions, job description, if any;

(5) contribution history from the federal social security administration for the claimed period of employment, if applicable.

B. Forfeited service credit may be reinstated by repayment of withdrawn member contributions, together with interest from the date of withdrawal to the date of repayment at the rate or rates set by the board, under the following conditions:

(1) Service credit may be reinstated in one-year increments, beginning with the most recently forfeited service credit. A one-year increment is 12 consecutive but not necessarily continuous months of service credit. For the purpose of eligibility to retire only, less than one year of service credit may be purchased. After reinstatement of all 12-month "years" as defined herein, any remaining service credit that totals less than 12 months may be reinstated by payment in one lump sum as provided herein.

(2) All forfeited service credit may also be reinstated by repayment of the total amount of all member contributions withdrawn from each period of service together with interest from the date of withdrawal to the date of repayment at the rate set by the board.

(3) A former member who is employed by an employer covered under the Educational Retirement Act must provide evidence of current contributing membership in the educational retirement association; such evidence shall be either certification by the employer, in the form prescribed by the association, or certification by the educational retirement association (ERA).

(4) Payment for reinstated service credit must be received by the association prior to the member's effective date of retirement.

(5) Interest received to reinstate forfeited service credit under this subsection shall not be refunded to the member. The purchase cost received to reinstate forfeited service credit which is determined to be unnecessary to provide the maximum pension applicable to the member and which is purchased in reliance on information provided by PERA shall be refunded to the member.

C. "Actual credited service" for purposes of NMSA 1978, Section 10-11-27 and Section 10-11-115.2 means only that service credit earned during periods of employment with the New Mexico state police in the positions of patrolman, sergeant, lieutenant, captain or aircraft division pilot, with the corrections department or its successor agency after July 1, 2004 in the positions of adult correctional officer or

adult correctional officer specialist, or as a municipal detention officer member [~~pursuant to NMSA 1978, Section 10-11-115.1~~]. No permissive service credit which is purchased by state police members [~~or~~], adult correctional officer members, or municipal detention officer members shall be increased by 20% as provided in NMSA 1978, Section 10-11-27 or Section 10-11-115.2. With respect to service credit acquired for periods of military service, only that service credit which is acquired for intervening military service during a period of employment as a state police member, an adult correctional officer member after July 1, 2004 or as a municipal detention officer member shall be increased by 20% [~~as provided in NMSA 1978, Section 10-11-27~~].

D. Military service credit is free in some cases and may be purchased in other cases as provided by statute.

(1) Where a member wishes to claim service credit pursuant to NMSA 1978, Section 10-11-6 the association shall, upon the member's request, furnish that member a form of affidavit for completion and certification of such service. The affidavit shall be accompanied by documentary evidence of the member's entry and discharge from service in a uniformed service of the United States.

(2) The affiliated public employer by whom the member was employed immediately prior to entering a uniformed service of the United States shall certify in writing the date the member stopped rendering personal service to the employer. This requirement may be waived if PERA records contain sufficient documentation to support the date the member stopped rendering personal service.

(3) The affiliated public employer by whom the member was employed immediately after discharge from a uniformed service of the United States shall certify in writing to the association the date the member started rendering personal service to the employer. This requirement may be waived if PERA records contain sufficient documentation of the date of return to employment. Members who are not reemployed by an affiliated public employer within ninety days following termination of the period of intervening service but who nevertheless claim reemployment rights under federal law shall provide to the association written certification from the affiliated public employer that the member is entitled to reemployment rights under the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

(4) The affidavit, employer certifications, and documentary evidence of uniformed service shall be presented to the association for approval.

(5) Service credit for periods of intervening service in the uniformed services following voluntary enlistment, reenlistment or appointment shall be awarded only upon compliance by the member and the affiliated public employer with the provisions of NMSA 1978, Section 10-11-6, as amended, and the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, including but not limited to the payment to the association of contributions required from the member and the employer.

(6) PERA members who are also members of the military service reserve components who are activated pursuant to a federal call to duty, deployment or peacekeeping mission or other declared national emergency may receive free service credit subject to the conditions of this section. The member must provide a form DD 214 or other documentation as required by PERA to support an award of free service credit.

E. A member who claims service credit for one or more periods of employment for which an employer failed to remit the required contributions to the association may receive service credit only after receipt by the association of payment by the employer of the delinquent contributions plus applicable interest and penalties, if any, along with the following documentation:

(1) payroll records for the claimed periods of employment, indicating the salary for the claimed employment dates;

(2) personnel action forms showing hire date(s), term of employment, job classification, salary amounts and dates of personnel actions;

(3) job description;

(4) contribution history from the federal social security administration for the claimed period of employment, if applicable;

(5) explanation from the employer as to why contributions were not withheld or paid to the association;

(6) any other information requested by the association; if original records have been lost or destroyed, affidavits in a form acceptable to the association may be submitted for the purpose of substantiating the employment; the association may accept such affidavits in lieu of original records if it deems them sufficient to establish the required employment information.

F. At any time prior to retirement, a member may purchase permissive service credit at its full actuarial present value as determined by the association, under the following conditions:

(1) Service credit may be purchased in one-month increments.

(2) The amount of service credit purchased under this Subsection (F) shall not exceed one year.

(3) Service credit purchased cannot be used for the purpose of calculating final average salary or eligibility for pension factor of a coverage plan for pension calculation and retirement purposes.

(4) For members employed in part-time positions, for purposes of calculating the full actuarial present value purchase cost of service credit under this Subsection (F), the member's hourly salary shall be annualized as if the member was employed full-time.

(5) Payment for service credit under this subsection must be received within sixty (60) days of the date the member is informed in writing of the purchase price of the service credit.

(6) The purchase cost received to purchase service credit under this subsection shall not be refunded to the member.

[10-15-97; 11-15-97; 1-15-99; 12-15-99; 2.80.600.20 NMAC - Rn & A, 2 NMAC 80.600.20, 8-15-01; A, 12-28-01; A, 9-30-03; A, 8-31-04; A, 6-30-05]

NEW MEXICO PUBLIC EMPLOYEES RETIREMENT ASSOCIATION

This is an amendment to 2.80.700 NMAC, Section 10, effective June 30, 2005.

2.80.700.10 PROCEDURE FOR RETIREMENT

A.

(1) The member shall request an application for retirement from PERA. To insure that the member may retire on the date the member has chosen, the completed application should be returned to PERA, with the required documents described in subsection B below, at least 60 days prior to the selected date of retirement. The completed application and all supporting documentation must be filed with PERA no later than the close of business on the last working day of the month prior to the selected date of retirement. Any changes to an application for retirement that has already been submitted to PERA, including, but not limited to, retirement date, designation of survivor beneficiary or form of payment option, must be in writing and filed with PERA no later than the close of business on the last working day of the month prior to the selected date of retirement.

(2) PERA shall furnish the member an estimate of retirement pension payable under form of payment A within a reasonable time of receipt of the properly completed application and required documents. If the member also desires an estimate of retirement pension payable under

forms of payment B, C and D, the member shall request such an estimate in writing.

(3) When the application is filed, PERA shall furnish the member's last affiliated public employer with an employer's certification of earnings form to be completed and returned to PERA. The final calculation of pension cannot be processed until PERA receives the properly completed employer's certification form.

(4) PERA will furnish the member a final calculation of retirement pension based on the information provided by the affiliated public employer.

(5) The completed application form must either include or be accompanied by a signed notarized statement of consent by the member's spouse to the form of payment and beneficiary elected by the member or an affidavit that the member is not married. An affidavit naming all former spouses must also accompany the final application form.

(6) The application shall be considered to be "filed" when PERA receives the completed application as evidenced by a writing on the application indicating the date of receipt by PERA.

(7) Retirement will be effective on the first day of the month following: a) the filing with PERA of the completed, signed application with all required documentation; b) the member's qualifying for retirement based on service and age; and c) the member's termination of non-exempt employment with all affiliated public employers.

(8) The retirement of the member shall be submitted to the board for ratification at the next regular meeting following the effective date of retirement.

B. The retiring member shall furnish the following documents to PERA:

(1) Proof of age of the member and any designated beneficiary or beneficiaries. Acceptable documents are a birth certificate, a baptismal certificate or religious record of birth established before age 5 years, or any two of the following documents showing the date of birth of the member or designated beneficiary or beneficiaries:

(a) copy of a life insurance policy;

(b) certified copy of voter registration issued over ten years prior;

(c) tribal census record;

(d) childhood immunization record made prior to age eighteen (18) years;

(e) military record;

(f) birth certificate of child showing age of parent;

(g) physician's or midwife's record of birth;

(h) passport;

(i) immigration record;

(j) naturalization record;

(k) social security records.

(2) A copy of a marriage certificate or other proof of marital status acceptable in a court of law for any designated beneficiary to be identified as a spouse.

(3) Complete endorsed copies of all court documents necessary to ascertain the current marital status of the member and whether any ex-spouse of the member is entitled to any portion of the member's benefits. Such documents shall include the final decrees and marital property settlements for all marriages during the member's employment with an affiliated public employer. If the member's only divorce was prior to becoming a PERA member, then the final divorce decree is required, but no marital property settlement is required. If the member was divorced more than once before becoming a PERA member, then only the most recent final decree is required. The requirement for providing a copy of a final decree may be waived, in PERA's discretion, when PERA can establish through online court records that a divorce decree was entered on a specific date and no further documentation is deemed necessary to administer benefits.

(4) Any member with an effective retirement date after December 31, 1998 shall provide authorization to the association for the electronic transfer of pension payments to the retiree's banking institution, or a waiver in lieu thereof. Such authorization or waiver shall be executed, in writing, in the form prescribed by the association.

C. No adjustments to the pension based on failure to claim free service credit may be made after the first pension payment.

D. If a member has three or more years of service credit under each of two or more coverage plans, the pension factor and pension maximum provided under the coverage plan which produces the highest pension shall apply. The coverage plan from which the member was last employed shall govern the age and service requirements for retirement. Permissive service credit purchased pursuant to NMSA 1978, Section 10-11-7(H) cannot be used to determine final average salary, pension factor or pension maximum for pension calculation purposes.

E. Upon meeting the membership requirements in 2.80.400 NMAC, a member shall combine concurrent salaries received from two affiliated public employers. In the case of concurrent full-time and part-time employment or full-time and elected official service, service credit shall be earned only for the full-time employment. In the case of two part-time employments, service credit shall be earned only for the employment which has the lowest pension factor and pension maximum. In the case of concurrent employment, termination from all affiliated public employers is required before retirement. No combining of concurrent salary may occur for employees who are on extended annual or sick leave until retirement.

F. A member is vested in his or her accrued benefits when the member reaches normal retirement age of the plan in which he or she is a member at the time of retirement or was last a member. If there is a termination of the PERA retirement system, or if employer contributions to the PERA fund are completely discontinued, the rights of each affected member to the benefits accrued at the date of termination or discontinuance, to the extent then funded, are non-forfeitable.

G. A member who retires must remain unemployed by an employer covered by any state system for a period of at least 90 days before returning to public employment. If the retired member is re-employed by an employer covered by any state system within 90 days of retirement, the member shall be immediately removed from retirement and any pension amounts paid since the member's retirement shall be considered an overpayment that must be reimbursed to PERA by the member. A retired member who performs work for an employer covered by any state system as an independent contractor under a contract approved by PERA is not subject to the provisions of this section. A retired member who works for an employer covered by the Judicial Retirement Act or the Magistrate Retirement Act and who is exempt or excluded from membership in that system under the applicable retirement act is not subject to the provisions of this section. A retired member who works for an employer affiliated with the educational retirement association is not subject to the provisions of this section.

[10-15-97; 11-15-97; 1-15-99; 12-15-99; 2.80.700.10 NMAC - Rn & A, 2 NMAC 80.700.10, 12-28-00; A, 8-15-01; A, 12-28-01; A, 9-30-03; A, 8-31-04; A, 6-30-05]

NEW MEXICO PUBLIC EMPLOYEES RETIREMENT ASSOCIATION

This is an amendment to 2.80.1400 NMAC, Section 10, effective June 30, 2005.

2.80.1400.10 GENERAL PROVISIONS

A. "Salary" is defined by each state system for that state system. Each system shall certify the member's salary as defined by that system to the payor

system, and the payor system shall accept that salary for pension calculation purposes where applicable.

B. The Public Employees Retirement Reciprocity Act applies to normal retirement only, and does not apply to disability retirement or pre-retirement survivor pensions.

C. PERA retiree: If a retired member whose service credit at retirement was acquired only under PERA is:

(1) subsequently employed by an employer covered under another state system, and

(2) the retired member becomes a contributing member of that system, and

(3) the retired member's PERA pension is suspended for the period of membership under that system, and

(4) the retired member acquires service credit under that system, then the subsequently acquired service credit is eligible reciprocal service credit; when the member terminates the subsequent employment and retires again, the subsequent retirement shall be governed by the provisions of the Public Employees Retirement Reciprocity Act.

D. Retiree under another state system: If a retired member whose service credit at retirement was acquired only under another state system is:

(1) subsequently employed by an employer covered under PERA, and

(2) the retired member becomes a contributing member of PERA, and

(3) the retired member's pension is suspended for the period of membership under PERA, and

(4) the retired member acquires service credit under PERA, then the subsequently acquired service credit is eligible reciprocal service credit; when the member terminates the subsequent employment and retires again, the subsequent retirement shall be governed by the provisions of the Public Employees Retirement Reciprocity Act.

E. Overlapping service credit.

(1) If a member has service credit for the same period of time for employment by public employers covered under different state systems, service credit may only be acquired under one state system for the period of overlapping service credit.

(2) If a member retires with service credit under more than one state system for an overlapping period, the member shall be granted service credit for this overlapping period as follows:

(a) PERA, JRA or MRA shall grant service credit earned for the months the member was employed by an employer covered under one or more of these systems in accordance with all applicable statutes and rules.

(b) ERA shall grant service credit for the quarters of ERA service credited to the member in accordance with all applicable ERA statutes and rules less the amount of service credit granted by PERA, JRA or MRA in subparagraph 2(a) above. In no case shall a member be credited with more than one month of service credit for all service in any calendar month.

F. Free or purchased military service credit under any state system may only be considered eligible reciprocal service credit under one state system for reciprocity retirement purposes.

G. When a member retires according to the provisions of the Public Employees Retirement Reciprocity Act or requests a service credit verification or benefits estimate, each state system under which the member has acquired eligible reciprocal service credit shall furnish the payor system with a certified statement of the member's service credit, and other pertinent data necessary to compute the member's pension.

H. A member retired according to the provisions of the Public Employees Retirement Reciprocity Act shall receive the same cost of living adjustments provided by each state system under which the retired member acquired eligible reciprocal service credit. Each state system shall pay the cost of living adjustment due under the provisions of that state system for the portion of the total pension attributable to service credit acquired under that state system.

I. A member retiring according to the provisions of the Public Employees Retirement Reciprocity Act shall only elect a form of payment option with the payor system. Each state system shall calculate benefits according to the same form of payment, except in the case of a member who retires under PERA and elects form of payment D, in which case the ERA component of the pension shall be calculated according to form of payment A.

[~~I~~] J. Amendments to this rule shall be effective only if adopted by the educational retirement board and the public employees retirement board.

[10-15-97; 11-15-97; 2.80.1400.10 NMAC - Rn, 2 NMAC 80.1400.10, 12-28-01; A, 9-30-03; A, 8-31-04; A, 6-30-05]

NEW MEXICO PUBLIC EMPLOYEES RETIREMENT ASSOCIATION

This is an amendment to 2.80.1600 NMAC, Section 30, effective June 30, 2005.

2.80.1600.30 FORM OF PAYMENT

A. When a retired member who has chosen either form of payment B or C with the retired member's spouse as the named survivor beneficiary is divorced, the retired member may either: 1) make no change in the form of payment and beneficiary; or 2) change the form of payment to form of payment A, which does not provide for a survivor beneficiary, if an appropriate court order so provides.

B. If the retired member elects to change from form of payment B or C to A, permission to make such an election must be included in a court order. PERA shall not be obligated to administer a change in form of payment in accordance with such an order until the first of the month following written approval by the office of general counsel.

C. A court order requiring an election of a particular form of payment at retirement shall be addressed to the non-retired member, and the member shall be responsible for executing the proper PERA forms and providing the documentation necessary to effectuate the election. A member who violates such an order may be in contempt of court.

[10-15-97; 11-15-97; 2.80.1600.30 NMAC - Rn, 2 NMAC 80.1600.30, 12-28-01; A, 9-30-03; A, 6-30-05]

NEW MEXICO PUBLIC EMPLOYEES RETIREMENT ASSOCIATION

This is an amendment to 2.80.2100 NMAC, Section 8, effective June 30, 2005.

2.80.2100.8 GENERAL PROVISIONS

A. No partial refund of a member's contributions is permitted.

B. A member shall not receive a refund of contributions if the member terminates employment with one affiliated public employer and is thereafter employed by the same or another affiliated public employer within thirty (30) days of termination. The application for a refund of member contributions, if desired, must be filed prior to any subsequent employment. If the application for refund is not filed within this period of time, no refund shall be permitted until termination of all affiliated public employment.

C. Requests for refunds of member contributions shall be made on forms provided by the association.

(1) The member or the member's legal representative, or the member's designated refund beneficiary or the beneficiary's legal representative, if the member is deceased, must complete and sign the

request for refund.

(2) If the member is deceased, the applicant for refund must provide PERA with a copy of the member's death certificate. If the deceased member has no living beneficiary, then the personal representative of the estate must provide PERA with a copy of the letters of administration or order of appointment of personal representative, signed and filed in court; or must comply with NMSA 1978, Section 45-3-1201.

(3) If the member has been divorced, the member shall provide PERA with complete endorsed copies of all court documents necessary to ascertain the current marital status of the member and whether any ex-spouse of the member is entitled to any portion of the member's contributions. Such documents shall include the final decrees and marital property settlements for all marriages during the member's employment with an affiliated public employer. If the member's only divorce was prior to becoming a PERA member, then the final divorce decree is required, but no marital property settlement is required. If the member was divorced more than once before becoming a PERA member, then only the most recent final decree is required. The requirement for providing a copy of a final decree may be waived, in PERA's discretion, when PERA can establish through online court records that a divorce decree was entered on a specific date and no further documentation is deemed necessary to administer benefits. If the member's former spouse is entitled to a portion of a refund of member contributions pursuant to a court order entered under NMSA 1978, Section 10-11-136, the member's former spouse may request, on a form prescribed by the association, that his or her share of a refund of member contributions be transferred directly to another qualified plan as allowed by the Internal Revenue Code.

(4) The member's last affiliated public employer must certify to the termination of employment of the member before a refund may be made.

(5) No refund shall be permitted unless a membership application is on file with PERA.

D. Interest on member contributions shall be posted annually effective June 30 of each year at the rate of 5.25%.

E. A refund of member contributions includes interest on those contributions as provided in this Rule. Effective July 1, 2004, a refund of member contributions includes interest on those contributions calculated through the last working day of the month prior to the date of refund.

F. A refund of member contributions shall not include the purchase cost received to buy permissive service credit pursuant to Section 10-11-7(H) NMSA 1978.

G. If a court order issued pursuant to Section 10-11-136 NMSA 1978 or Section 10-11-136.1 NMSA 1978 restraining, withholding, or dividing a refund of member contributions is received by PERA after a request for refund of contributions has been received but has not been paid, PERA will comply with the order.

H. Pursuant to Section 10-11-135, NMSA 1978, PERA retirement accounts are not subject to legal process under other state laws, except for division of a community interest in such accounts as provided in Section 10-11-136 NMSA 1978 or in enforcement of child support obligations as provided in Section 10-11-136.1 NMSA 1978. In the following instances, however, federal laws pre-empt the provisions of the Public Employees Retirement Act.

(1) IRS notices of levy for unpaid taxes will be honored if the account is in pay status, i.e., if the member has terminated employment and requested a refund of contributions, or if a pension is payable. If the levy is applied against a refund of member contributions, non-tax deferred contributions shall be paid before tax-deferred contributions.

(2) Orders by a U.S. bankruptcy court will be honored if the account is in pay status, i.e., if the member has terminated employment and requested a refund of contributions, or if a pension is payable. If the order is applied against a refund of member contributions, non-tax deferred contributions shall be paid before tax-deferred contributions.

I. Members may designate only one refund beneficiary. Such designation shall be in writing in the form prescribed by PERA. If the refund beneficiary is other than a natural person, the member shall provide documentation as required by the association. The member shall be responsible for updating the beneficiary designation form with current information, including but not limited to the beneficiary's name and address. If a warrant for a refund to the most recent beneficiary on file with the association is returned as undeliverable because of incorrect name or address, the money will remain with the association until it is furnished with the correct information.

J. Forfeitures arising from severance of employment, death, or any other reason, must not be applied to increase the benefits any member would otherwise receive under the plan. PERA shall make all reasonable efforts to refund contributions or to pay pensions as required by the plan.

K. The maximum annual contribution limits contained in Internal Revenue Code Section 415(c), as amended and adjusted, are incorporated herein by reference.

L. For purposes of the direct rollover provisions in NMSA 1978, Section 10-11-124(C), another qualified plan shall mean an IRA, an Internal Revenue Code Section 401(a) plan, an Internal Revenue Code Section 401(k) plan, an annuity contract under Internal Revenue Code Section 403(b) and an eligible plan under Internal Revenue Code Section 457 that is maintained by a state or political subdivision and which agrees to separately account for amounts transferred into such a plan from the PERA retirement plan. The definition of eligible retirement plan shall also apply in the case of a distribution to a surviving spouse or to a spouse or former spouse who is the alternate payee under an order dividing PERA benefits. After tax-employee contributions shall be paid directly to the member.

[10-15-97; 11-15-97; 12-15-99; 2.80.2100.8 NMAC - Rn & A, 2 NMAC 80.2100.8, 12-28-00; A, 12-28-01; A, 9-30-03; A, 6-30-05]

NEW MEXICO COMMISSION OF PUBLIC RECORDS

Notice of Repeal

1 NMAC 3.2.10.1, Records Custody and Access, is hereby repealed and replaced by 1.13.10 NMAC, Records Custody, Access, Storage and Disposition, effective June 30, 2005.

1 NMAC 3.2.20.3, Storage of Electronic Media at the State Records Center and Archives, is hereby repealed and replaced by 1.13.20 NMAC, Storage of Disaster Recovery Backup Files at the State Commission of Public Records - State Records Center and Archives, effective June 30, 2005.

NEW MEXICO COMMISSION OF PUBLIC RECORDS

TITLE 1 GENERAL GOVERNMENT ADMINISTRATION
CHAPTER 13 PUBLIC RECORDS
PART 7 NEW MEXICO OFFICE OF THE STATE HISTORIAN SCHOLARS PROGRAM

1.13.7.1 ISSUING AGENCY: State Commission of Public Records - State Records Center and Archives
[1.13.7.1 NMAC - N, 06/30/05]

1.13.7.2 SCOPE: Scholars meeting the eligibility requirements set forth in 1.13.7 NMAC and seeking financial assistance to pursue qualifying historical research at the state records center and archives.
[1.13.7.2 NMAC - N, 06/30/05]

1.13.7.3 STATUTORY AUTHORITY: Section 14-3-6 NMSA 1978 provides that the state records administrator shall adopt regulations necessary for carrying out the Public Records Act, which governs the management of the public records, including those held in the state archives. Laws 2005, Chapter 34, Section 4, Subsection E, Paragraph (1) provides funding for fiscal year 2006 for the New Mexico history scholars program.
[1.13.7.3 NMAC - N, 06/30/05]

1.13.7.4 DURATION: June 30, 2006.
[1.13.7.4 NMAC - N, 06/30/05]

1.13.7.5 EFFECTIVE DATE: June 30, 2005, unless a later date is cited at the end of a section.
[1.13.7.5 NMAC - N, 06/30/05]

1.13.7.6 OBJECTIVE: To promote understanding and appreciation of New Mexico history by providing financial assistance to eligible applicants to defray living costs while conducting historical research at the state records center and archives.
[1.13.7.6 NMAC - N, 06/30/05]

1.13.7.7 DEFINITIONS:

A. Fellowship means a stipend awarded by the state records center and archives for the purpose of defraying the costs incurred by recipients of residing in Santa Fe while conducting historical research at the state records center and archives.

B. Historical research means, for purposes of 1.13.7.NMAC, research conducted using primary sources from the archival collections at the state records center and archives.

C. Independent scholar means an individual, regardless of academic credentials, who is recognized as an authority in any field or discipline that advances understanding and appreciation of New Mexico history. Independent scholars may include individuals such as community historians, tribal elders, etc.
[1.13.7.7 NMAC - N, 06/30/05]

1.13.7.8 ELIGIBILITY: Applicants for fellowships shall meet the requirements described below.

A. An applicant shall be a citizen of the United States or a foreign national who is legally residing in the United State and who:

(1) is enrolled in a graduate program in an accredited college or university and is conducting research toward a graduate degree at that institution, subject to the provisions of Subsection B of 1.13.7.8 NMAC;

(2) holds a graduate degree in a field or discipline from an accredited college or university, subject to the provisions of Subsection B of 1.13.7.8 NMAC; or

(3) is an independent scholar.

B. An applicant may be studying or working in any field or discipline, provided that the research proposed shall foster an understanding and an appreciation of New Mexico history and that his or her academic or work experience shall qualify him or her to conduct the proposed research.

C. An applicant shall reside outside a 60-mile radius of Santa Fe, NM at the time of application.

D. An applicant shall demonstrate financial need.
[1.13.7.8 NMAC - N, 06/30/05]

1.13.7.9 FELLOWSHIPS - TERMS AND CONDITIONS:

A. Fellowships shall be awarded for a maximum of $1,000 per month. The amount of a fellowship shall be determined by the financial need demonstrated by the successful applicant and budget availability. The funding shall be used only to defray living costs incurred as a result of the required Santa Fe residency and shall be made available on a reimbursement basis only, as specified in 1.13.7.11 NMAC.

B. The duration of a fellowship shall be one to two months, except as provided in Subsection C of 1.13.7.9 NMAC, and shall be determined by the nature of the proposed research project and budget availability.

C. A fellowship with duration of greater than two months may be awarded, if the proposed research is sufficiently extensive and the benefit to the state of New Mexico and to the advancement of an understanding and an appreciation of New Mexico is determined to be sufficiently significant. The sufficiency of the research and the significance of the benefit shall be determined by the fellowship awards committee.

D. Fellowships shall be awarded only for research projects based on research conducted using primary sources available in the state archives of the state records center and archives. A minimum of 30 hours per month of on-site research in the state archives shall be required.

E. Fellowships shall be awarded only for research projects that shall benefit the state of New Mexico and its citizens by advancing understanding and appreciation of New Mexico history.

F. Each fellow shall be required to submit a report of research findings within one month of completing a fellowship. In addition, the fellow will be asked to submit any completed research findings that result in reports, papers, chapters and manuscripts to the state records center and archives. All submitted material shall be included in the state archives unpublished manuscript collection and shall be accessible to the public. Failure to comply with this requirement shall require immediate reimbursement to the state of the fellowship award. These requirements shall be further defined in the acceptance agreement.
[1.13.7.9 NMAC - N, 06/30/05]

1.13.7.10 APPLICATION FOR FELLOWSHIP:

A. An applicant for a fellowship shall complete an application package that shall contain the following items.

(1) A signed cover letter that shall contain, at a minimum:

(a) a statement explaining the applicant's interest in the scholar's program;

(b) the eligibility criterion under which the application is being made (see 1.13.7.8 NMAC);

(c) the length of the fellowship requested and the preferred dates of the fellowship (within the time limits set forth in 1.13.7.14.NMAC); and

(d) the amount of the fellowship requested and a detailed explanation of financial need (see 1.13.7.9 NMAC).

(2) An abstract, not to exceed 300 words, which shall define the topic of the proposed research and summarize its purpose and objectives.

(3) A research proposal, no more than six pages in length, which shall describe what is to be accomplished during the fellowship period; the status of the applicant's research on the proposed research topic; the specific relevance of the state records center and archives' collections to the project; the significance of the research to the advancement of an understanding and an appreciation of New Mexico history; and the expected results or products of the research.

(4) An up-to-date curriculum vitae, which shall not exceed four pages and which shall also, in addition to academic and work experience, reflect the applicant's full name; residential and, if applicable, business addresses; and residential and, if applicable, business telephone numbers and e-mail addresses.

(5) Copies of certified transcripts or of diplomas, if the application is made

pursuant to an eligibility criterion requiring award of academic degrees or enrollment in an academic program (see 1.13.7.8 NMAC).

(6) Two letters of support. If the applicant is a graduate student enrolled in a Ph.D. program, one of the letters shall be from the applicant's dissertation chair or advisor. If the applicant is enrolled in a master's degree program, one of the letters shall be from the student's graduate advisor. Original copies of the letters may be included with the application or may be forwarded directly from the supporters. If the applicant chooses the latter option, he or she shall include a statement to that effect in the application package, and the applicant shall be responsible for ensuring that the letters of support are received timely.

B. The cover letter, the abstract, the proposal and the curriculum vitae shall be produced using word processing software, shall be in 12-point type (preferably Times New Roman) and shall be double-spaced, with one-inch margins on all sides.

C. The application package shall be collated (clipped, not stapled) and five copies submitted by the deadlines provided in 1.13.7.14 NMAC.

D. Incomplete applications shall not be considered for funding; however, they shall not be returned.

[1.13.7.10 NMAC - N, 06/30/05]

1.13.7.11 FUNDING AND COMPENSATION:

A. The New Mexico office of the state historian scholars program is a pilot project, currently funded through a one-year special appropriation expiring June 30, 2006.

B. Although an applicant shall request, pursuant to 1.13.7.10 NMAC, a fellowship for a given amount, duration and time, the decisions concerning these issues shall be made by the fellowship awards committee and shall be based on funding availability, the nature of the proposed research and access to collections and the number of fellowships awarded. All research conducted under a fellowship shall be completed by the end date of the fellowship period and, in all cases, no later than May 31, 2006.

C. A successful applicant shall enter into an acceptance agreement issued by the state records center and archives, which shall describe the specific research topic, research requirements, specific deliverables, timetables and compensation provisions.

D. As set forth in 1.13.7.8 NMAC, compensation shall not exceed $1000 per month and shall be rendered on a reimbursement basis. For fellowship of one-month duration, payment shall be made at the conclusion of the fellowship, subject to the successful completion of all fellowship requirements and the submittal of an itemized accounting of expenses, including receipts, for which reimbursement is sought. For fellowship of duration of longer than one month, reimbursement may be made monthly, subject to the successful completion of identified deliverables and submittal of an itemized accounting of expenses, including receipts, for which reimbursement is sought. The reimbursement requirements shall be delineated in the acceptance agreement.

[1.13.7.11 NMAC - N, 06/30/05]

1.13.7.12 REVIEW AND AWARD PROCESS:

A. The staff of state records center and archives (office of the state historian) shall conduct an initial review of all applications to ensure that all required materials have been received and that the applicant meets the minimum qualifications. Applicants who do not meet minimum qualifications or whose applications are incomplete shall be notified in writing; however, application packages shall not be returned.

B. Qualifying applications shall be reviewed and rated and fellowships awarded, using an established rating system which shall take into consideration such factors as qualifications of the applicant, demonstration of financial need, use of state archival collections, practicality of the proposal, value and use of proposed research in the advancement of the understanding and appreciation of New Mexico history and budget availability.

C. Qualifying applications shall be reviewed and rated and awards made by a fellowship awards committee. Members of the committee shall be the state records administrator, the state historian, the director of the archives and historical services division of the state records center and archives and two members from outside the state records center and archives who shall be qualified by academic credentials or experience to evaluate the significance of the historical research proposed. The two members shall be appointed by the state historian, subject to the approval of the state records administrator. Members of the committee shall serve without compensation and shall declare any conflict of interest with respect to any applicant and shall not participate in the evaluation of any application where such a conflict may exist.

D. During the review process, the committee may request clarifying information from applicants, but the decisions of the committee shall be final.

[1.13.7.12 NMAC - N, 06/30/05]

1.13.7.13 POST-AWARD REQUIREMENTS: Successful fellowship applicants shall comply with the following post-award requirements.

A. Fellows shall reside within a 60-mile radius of Santa Fe, NM during the fellowship period, and research work shall take place at the state records center and archives.

B. Prior to the conclusion of the fellowship period, each fellow shall be required to give a public lecture based on the research accomplished during the fellowship period.

C. Each fellow shall be required to submit a report of research findings within one month of completing a fellowship. In addition, the fellow will be asked to submit any completed research findings that result in reports, papers, chapters and manuscripts to the state records center and archives. All submitted material shall be included in the state archives unpublished manuscript collection and shall be accessible to the public. Failure to comply with this requirement shall require immediate reimbursement to the state of the fellowship award. These requirements shall be further defined in the acceptance agreement.

[1.13.7.13 NMAC - N, 06/30/05]

1.13.7.14 TIMETABLE - APPLICATIONS AND AWARDS:

A. Completed applications shall be received in the state records center and archives by 3:00 pm, on August 1, 2005 and January 1, 2005 respectively as the two deadlines set by the call for applications.

B. The staff of the state records center and archives shall conduct an initial review to determine if applications are complete and applicants meet minimum qualification within ten working days of the receipt of applications.

C. The fellowship review committee shall conduct its review and evaluation process of qualifying applications and award fellowships within one month of receipt of applications.

D. Successful applicants shall notify the state records center and archives (office of the state historian) of their acceptance or rejection of fellowships within five days of notification. Notification shall be made by e-mail, or if the applicant has no e-mail address, by registered U.S. mail, return receipt requested.

E. Acceptance agreements shall be completed and signed prior to the beginning of research or within one month of notification of acceptance, which ever is earlier.

F. All research and deliverables identified in the acceptance agreement shall be completed by the end of the fellowship period, but in all cases no later

than May 31, 2006.
[1.13.7.14 NMAC - N, 06/30/05]

HISTORY OF 1.13.7 NMAC: [RESERVED]

NEW MEXICO COMMISSION OF PUBLIC RECORDS

TITLE 1 GENERAL GOVERNMENT ADMINISTRATION
CHAPTER 13 PUBLIC RECORDS
PART 10 RECORDS CUSTODY, ACCESS, STORAGE AND DISPOSITION

1.13.10.1 ISSUING AGENCY: State Commission of Public Records - State Records Center and Archives
[1.13.10.1 NMAC - Rp, 1 NMAC 3.2.10.1.1, 6/30/2005]

1.13.10.2 SCOPE: All state agencies as well as local governments.
[1.13.10.2 NMAC - Rp, 1 NMAC 3.2.10.1.2, 6/30/2005]

1.13.10.3 STATUTORY AUTHORITY: Section 14-3-8 NMSA 1978 establishes a records center under the supervision and control of the administrator. The record center in accordance with the regulations established by the administrator and the commission shall be the facility for the receipt, storage or disposition of all inactive and infrequently used records of present or former state agencies. Section 14-3-6 NMSA 1978 provides the state records administrator the authority to establish records and information management programs for the application of efficient and economical management methods for the creation, utilization, maintenance, retention, preservation and disposal of public records.
[1.13.10.3 NMAC - Rp, 1 NMAC 3.2.10.1.3, 6/30/2005]

1.13.10.4 DURATION: Permanent.
[1.13.10.4 NMAC - Rp, 1 NMAC 3.2.10.1.4, 6/30/2005]

1.13.10.5 EFFECTIVE DATE: June 30, 2005 unless a later date is cited at the end of a section.
[1.13.10.5 NMAC - Rp, 1 NMAC 3.2.10.1.5, 6/30/2005]

1.13.10.6 OBJECTIVE: To establish requirements for the custody, access, storage and disposition to records stored at the state records center and archives by state agencies and local government.
[1.13.10.6 NMAC - Rp, 1 NMAC 3.2.10.1.6, 6/30/2005]

1.13.10.7 DEFINITIONS:

A. "Administrator" means the state records administrator (Section 14-3-2 NMSA 1978).

B. "Agency" means any state agency, department, bureau, board, commission, institution or other organization of state government, the territorial government and the Spanish and Mexican governments in New Mexico (Section 14-3-2 NMSA 1978).

C. "Custodial agency" means the agency responsible for the maintenance, care, or keeping of public records, regardless of whether the records are in that agency's actual physical custody and control.

D. "Human readable form" means information that can be recognized and interpreted without the use of technology.

E. "Master microfilm" means the original microform produced from which duplicates or intermediates can be obtained.

F. "Pick-up only personnel" means personnel authorized by a records custodian or record liaison officer only pick-up records from the state records center and archives (state records center).

G. "Public records" means all books, papers, maps, photographs or other documentary materials, regardless of physical form or characteristics, made or received by any agency in pursuance of law or in connection with the transaction of public business and preserved, or appropriate for preservation, by the agency or its legitimate successor as evidence of the organization, functions, policies, decisions, procedures, operations or other activities of the government, or because of the informational and historical value of data contained therein. (Section 14-3-2 NMSA 1978).

H. "Records" means information preserved by any technique in any medium now known, or later developed, that can be recognized by ordinary human sensory capabilities either directly or with the aid of technology (1.13.70 NMAC).

I. "Records custodian" means the statutory head of the agency using or maintaining the records or the custodian's designee.

J. "Records liaison officer" means a person in an agency responsible for authorizing the transfer, withdrawal or destruction of records and who acts on behalf of the records custodian.

K. "Retention" means the period of time during which records shall be maintained by an organization because they are needed for operational, legal, fiscal, historical or other purposes. Retention requirements are established in records retention and disposition schedules that are approved by the state commission of public records.

L. "Records retention and disposition schedules" means rules adopted by the state commission of public records pursuant to Section 14-3-6 NMSA 1978 describing records of an agency, establishing a timetable for their life cycle and providing authorization for their disposition.
[1.13.10.7 NMAC - Rp, 1 NMAC 3.2.10.1.7, 6/30/2005]

1.13.10.8 CUSTODY OF RECORDS: Agency records stored at the state records center and archives (state records center) shall remain in the custody of the records custodian of the custodial agency until such time as they are:

A. withdrawn permanently by the records custodian or the designated records liaison officer of the custodial agency;

B. destroyed with written approval from the state records administrator and the written consent of the records custodian or designated records liaison officer of the custodial agency and in accordance with retention periods established in records retention and disposition schedules; or

C. transferred to the state records center and archives (archives) with the written approval of the state records administrator and the consent of the records custodian or a designated records liaison officer of the custodial agency.
[1.13.10.8 NMAC - Rp, 1 NMAC 3.2.10.1.8, 6/30/2005]

1.13.10.9 RECORDS LIAISON OFFICER:

A. A records liaison officer may be designated by a records custodian to handle the storage, withdrawal and access or transfer of agency records to the state records center and archives.

B. All records liaison officers shall attend the required basic records management training offered by the state records center and archives before they can store, withdraw or access records stored in the records center.

C. Records liaison officers shall be required to attend additional training when notified by the state records center and archives of changes to records management policies, procedures or regulations.

D. The records liaison officer shall be re-appointed annually by the record custodian, using a form approved by the state records administrator.

E. The form shall include but not limited to the following: name and signature of the records custodian (agency

head or cabinet secretary); name and signature of the records liaison officer; division or bureau (if acceptable); agency code; agency name and mailing address; fiscal year of designation; phone number; fax number and e-mail address.

F. If a records liaison officer leaves the employment of an agency or is released from records management duties, the agency shall immediately notify the state records center and archives (agency analysis bureau) regarding the change, and the records custodian shall appoint a new records liaison officer.

[1.13.10.9 NMAC - Rp, 1 NMAC 3.2.10.1.9, 6/30/2005]

1.13.10.10 PICK-UP ONLY PERSONNEL:

A. Pick-up only personnel may be designated by a records custodian or a records liaison officer to pick up agency records from the records center.

B. Pick-up personnel shall be appointed annually, using a form approved by the state records administrator. The form shall include but not be limited to the following: name and signature of the records custodian (agency head or cabinet secretary); name and signature of the records liaison officer; pick-up personnel's name and signature; section/unit; agency code; agency name and mailing address; fiscal year of designation; phone number; fax number and e-mail address.

C. If a pick-up only designee leaves the employment of an agency or is released from the duty of picking up records, the agency shall immediately notify the state records center and archives (agency analysis bureau) regarding the change.

[1.13.10.10 NMAC - Rp, 1 NMAC 3.2.10.1.11, 6/30/2005]

1.13.10.11 WITHDRAWAL OF AND ACCESS TO RECORDS IN CUSTODY OF THE CUSTODIAL AGENCY:

A. Withdrawal of and access to agency records stored at the state records center and archives (records center) shall be authorized in writing by the records custodian or the designated records liaison officer of the custodial agency and submitted to the records center.

B. Requests by the public to access agency records stored at the state records center shall be made to the records custodian or the records liaison officer of the custodial agency. Access shall be authorized in writing by the records custodian or the records liaison officer of the custodial agency.

C. Requests to review records on-site at the state records center and archives (state records center) by the custodial agency shall be authorized by the records custodian or the records liaison officer.

D. The custodial agency may permanently withdraw records stored at the state records center.

E. Record custodian or records liaison officers shall temporarily withdraw the records of the custodial agency from storage by making a request in writing and signing a withdrawal form. The form shall include but not limited to the following; name and signature of the records liaison officer; date and time of transaction; agency name; agency address; records liaison officer's phone number; date requested; destination; box number; shipment box number; barcode; location; folder number; record series item number; description; and return date.

F. Requests to access agency records made under the Inspection of Public Records Act shall be referred by the state records administrator to the custodial agency.

[1.13.10.11 NMAC - Rp, 1 NMAC 3.2.10.1.12, 6/30/2005]

1.13.10.12 ACCESS TO RECORDS IN THE CUSTODY OF THE STATE RECORDS CENTER AND ARCHIVES: Access to records transferred to the state records center and archives (archives) shall be in accordance with procedures established by the state records administrator (see 1.13.11 NMAC).

[1.13.10.12 NMAC - Rp, 1 NMAC 3.2.10.1.13, 6/30/2005]

1.13.10.13 STORAGE OF PAPER RECORDS WITH A FINITE RETENTION AT THE STATE RECORDS CENTER AND ARCHIVES:

A. The state records center and archives (state records center) provides storage to state agencies for active and inactive public records. Non-record materials shall not be submitted for storage in the records center.

B. Agencies records liaison officers shall complete a storage transmittal form and submit it to the agency analysis bureau for approval before records can be stored. The form shall contain but not limited to the following: agency code; agency name; division name; date prepared; page number; office location; name and signature of the records liaison officer; records liaison officer telephone number; records liaison officer fax number; schedule item number; record description; disposition trigger date; destroy date; shipment box number and media type.

C. Agencies approved to store records shall be provided with barcode labels by the records center.

D. The barcode labels shall be affixed to the records storage boxes prior to delivery to the records center. The labels shall be placed two to three inches below the handle side of the storage box.

E. The records custodian and records liaison officer shall be notified by the records center when records in storage have met the legal retention period and are eligible for destruction.

F. If an agency does not respond to the records center's *notice of records eligible for destruction* by the established deadline, the state records center and archives will charge the custodial agency a storage fee as established in 1.13.2 NMAC, Fees.

[1.13.10.13 NMAC - N, 6/30/2005]

1.13.10.14 STORAGE OF PERMANENT PAPER RECORDS:

A. Records with the disposition of transfer to archives, which include records with the retention of permanent or transfer to archives, shall include an index approved by the state records center and archives that describes the contents of the box. The index shall include the following: name of agency; date of shipment; permanent box number; shipment box number; schedule item number; record series title; the beginning and ending dates of the record series; confidentiality note if any; and records liaison officer or the records custodian name.

B. A copy of the index shall be placed in the storage box and a second copy shall be submitted with the corresponding storage transmittal form or request for disposition form.

C. The storage transmittal form and the request for disposition form shall have an attached index before the boxes are approved for storage or transfer. All file folders in the box shall be clearly labeled and identify the contents of the folder.

D. The records custodian and the records liaison officer will be notified by the records center when records are eligible for transfer to the state archives.

[1.13.10.14 NMAC - N, 6/30/2005]

1.13.10.15 STORAGE OF ELECTRONIC RECORDS:

A. An agency shall complete a storage transmittal form and submit it to the state records center and archives (agency analysis bureau) for approval. An agency records liaison officer may contact the state records center and archives (records management division) for information and assistance with storage.

(1) The storage transmittal form shall be signed by the agency's records custodian or records liaison officer.

(2) At a minimum, each individual unit (tape, disk, etc.) of electronic media shall be clearly identified with the agency

name, record series and disposition date.

B. Withdrawal and access to electronic retention files shall be through the standard records center procedure for access and withdrawal of records. For information on record withdrawal procedures see 1.13.10.11 NMAC.

C. Agencies are responsible for safeguarding against storage media deterioration and technology changes that can leave electronic records inaccessible over a period of time because of hardware or software obsolescence. To eliminate the possibility of creating a situation where information can no longer be retrieved, agencies shall provide for future record accessibility by:

(1) migrating all electronic records when there are major changes to the next generation of hardware or software; or

(2) migrating only current electronic records to new hardware or software, and converting records not migrated to "human readable form."

D. The records custodian and records liaison officer shall be notified by the records center when records in storage have met the legal retention period and are eligible to be transferred to archives or are eligible for destruction.

[1.13.10.15 NMAC - N, 6/30/2005]

1.13.10.16 STORAGE OF MICROFILM:

A. An agency shall have an approved microphotography plan on file with the state records center and archives (electronic records and micrographic bureau) before master microfilm can be stored. For information on microphotography systems and standards see 1.14.2 NMAC.

B. The microphotography plan shall specify that the master microfilm will be stored at the state records center and archives (electronic records and micrographics bureau).

C. Microfilm shall pass inspection before it is approved for storage. Information on microfilm that has passed inspection will be entered into a computer tracking system by the electronic records and micrographics bureau staff. The computer system assigns permanent container numbers.

D. Microfilm inspection sheets shall be returned to the custodial agency with a notation indicating the assigned permanent container numbers.

E. It is the responsibility of the custodial agency to notify the microfilm vendor under contract that the microfilm has passed inspection.

F. After the microfilm has passed inspection and has been approved for storage the custodial agency shall submit a *request for disposition* form to the state records center and archives (agency analysis bureau) requesting authorization to dispose of the source documents.

G. If the microfilm has failed inspection, the electronic records and micrographics bureau staff shall notify the agency by letter that the microfilm can not be stored and that source documents shall be re-filmed before they can be destroyed.

H. For the procedure on withdrawal and access of records stored at the electronic records and micrographics bureau, see 1.13.10.11 NMAC.

I. The records custodian and records liaison officer shall be notified by the records center when records in storage have met the legal retention period and are eligible to be transferred to archives or are eligible for destruction.

J. If an agency does not respond to the records center's *notice of records eligible for destruction* by the established deadline, the state records center and archives will charge the custodial agency a storage fee as established in 1.13.2 NMAC, Fees.

[1.13.10.16 NMAC - N, 6/30/2005]

1.13.10.17 DISPOSITION:

A. The state records center is responsible for reviewing and applying the appropriate retention to records brought in for storage. The records center shall notify records custodians and records liaison officers when the custodial agency's records are eligible for disposition.

B. The state records administrator shall provide the custodial agency with a report of records eligible for either destruction or transfer to archives. The notice shall contain but not limited to the following; name of agency; agency code; date; number of record series eligible for destruction; method of destruction; location, barcode; record series item number; shipment box number; shipment date; description; and inclusive record series dates.

C. Upon receiving a notification of records eligible for destruction the custodial agency shall review the report of records to be destroyed and respond by the established deadline.

D. The custodial agency may request an exception to remove records from destruction if; the records identified in the notice are involved in litigation; the records identified in the notice are involved in active investigation; or the records identified in the notice are involved in an audit. The custodial agency shall submit the request for an exception in writing to the state records administrator and cite the exception (e.g., pending litigation, audit in process, audit pending, etc.).

E. The destruction notice shall have the written approval from the state records administrator with the written consent of the records custodian or designated records liaison officer prior to the execution of the destruction.

F. If an agency does not respond to the records center's *notice of records eligible for destruction* by the established deadline, the state records center and archives shall charge the custodial agency a storage fee for the storage of records that are eligible for destruction. For information on the fee schedule see 1.13.2 NMAC.

[1.13.10.17 NMAC - N, 6/30/2005]

HISTORY OF 1.13.10 NMAC:

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

SRC Rule 93-07, Policy on Custody of Records Stored by the Records Center, filed 6/1/93.

History of Repealed Material:

1 NMAC 3.2.10.1, Records Custody and Access - Repealed 6/30/2005.

NEW MEXICO COMMISSION OF PUBLIC RECORDS

TITLE 1 GENERAL GOVERNMENT ADMINISTRATION
CHAPTER 13 PUBLIC RECORDS
PART 20 STORAGE OF DISASTER RECOVERY BACKUP FILES AT THE STATE COMMISSION OF PUBLIC RECORDS - STATE RECORDS CENTER AND ARCHIVES

1.13.20.1 ISSUING AGENCY: State Commission of Public Records - State Records Center and Archives

[1.13.20.1 NMAC - Rp, 1 NMAC 3.2.20.3.1, 6/30/2005]

1.13.20.2 SCOPE: All state agencies.

[1.13.20.2 NMAC - Rp, 1 NMAC 3.2.20.3.2, 6/30/2005]

1.13.20.3 STATUTORY AUTHORITY: Section 14-3-8 NMSA 1978. A records center is established in Santa Fe under the supervision and control of the administrator. The center, in accordance with the regulations established by the administrator and the commission, shall be the facility for the receipt, storage or disposition of all inactive and infrequently used records Section 14-3-6 NMSA 1978 provides the state records administrator the authority to establish records and information management programs for the application of efficient and economical management methods for the creation, utilization,

maintenance, retention, preservation and disposal of public records.
[1.13.20.3 NMAC - Rp, 1 NMAC 3.2.20.3.3, 6/30/2005]

1.13.20.4 DURATION: Permanent.
[1.13.20.4 NMAC - Rp, 1 NMAC 3.2.20.3.4, 6/30/2005]

1.13.20.5 EFFECTIVE DATE: June 30, 2005 unless a later date is cited at the end of a section.
[1.13.20.5 NMAC - Rp, 1 NMAC 3.2.20.3.5, 6/30/2005]

1.13.20.6 OBJECTIVE: To establish procedures for offsite storage of disaster recovery backup files and electronic media at the state records center and archives.
[1.13.20.6 NMAC - Rp, 1 NMAC 3.2.20.3.6, 6/30/2005]

1.13.20.7 DEFINITIONS:

A. "Administrator" means the state records administrator (Section 14-3-2 NMSA 1978).

B. "Agency" means any state agency, department, bureau, board, commission, institution or other organization of the state government, the territorial government and the Spanish and Mexican governments in New Mexico (Section 14-3-2 NMSA 1978).

C. "Commission" means the state commission of public records (Section 14-3-2 NMSA 1978).

D. "Electronic disaster recovery files" means the process of creating a secondary copy of data for the purpose of disaster recovery, i.e., being able to recover or restore the data should an unplanned event make the primary data inaccessible.
[1.13.20.7 NMAC - Rp, 1 NMAC 3.2.20.3.7, 6/30/2005]

1.13.20.8 SPACE AVAILABILITY: The state records center and archives provides secure, vault storage for public records contained in electronic disaster recovery files. This service is dependent on the space available.
[1.13.20.8 NMAC - Rp, 1 NMAC 3.2.20.3.8, 6/30/2005]

1.13.20.9 DISASTER RECOVERY BACKUP FILES:

A. An agency requesting permission to store electronic disaster recovery files with the state records center and archives shall complete the request to store electronic disaster recovery files form.

B. The form approved by the state records administrator shall include but not limited to the following: agency name; name of contact person; division; phone number; fax number; physical address; mailing address; e-mail address; names of persons authorized to access and retrieve disaster recovery files; signature of authorized personnel; type and quantity of media; description of electronic media contents; name and signature of agency record custodian; and signature of the state records administrator.

C. The *request to store electronic disaster recovery files* form shall be re-submitted to the state records administrator when changes are made that differ from the original request (e.g., deleting or adding authorized personnel).

D. At a minimum, each individual unit (tape, disk, etc.) of disaster recovery backup files shall be clearly identified with the agency name.

E. Access.

(1) Access to disaster recovery backup files is permitted through the use of an automated key system. Key cards shall be issued to agencies by the state records center and archives when a request for storage of electronic disaster recovery files is approved.

(2) Lost key cards shall be reported immediately to the state records administrator so that the keys can be deactivated on the automated key system. Key cards shall be replaced at cost plus five percent processing fee.

(3) Regular access to electronic media shall be between the hours of 8:00 a.m. to 12:00 noon and 1:00 p.m. to 5:00 p.m., Monday through Friday.

(4) Authorized agency personnel requesting after hours access to electronic media shall be required to provide personal identification prior to access.

(5) Agencies requiring twenty-four hour Monday through Sunday access to disaster recovery backup files shall make such requests to the state records administrator. Requests shall state the reasons for requiring around the clock access to disaster recovery backup files. The state records administrator shall review all requests and shall either approve or deny such access.

F. Storage and terms of use.

(1) The state records center and archives shall provide locker(s) within a secured environmentally controlled vault.

(2) The requesting agency shall be required to provide the pad lock for the locker(s).

(3) If an agency abandons a locker it may forfeit future use of the vault storage.

(4) No food or drink is allowed in the vault.

(5) Before entering the vault, all authorized personnel are required to sign-in on the log provided by the state records center and archives.

(6) Only authorized personnel are allowed in the vault.

(7) Authorized personnel are not allowed to move furniture or equipment into the vault.

(8) Agencies that fail to comply with the "terms of use" may have their vault services terminated.

G. Renewal of authorization.

(1) At the close of the calendar year, agencies shall receive a notice from the state records center and archives asking agencies to review and update the authorization list.

(2) Agencies shall have 15 working days to respond to the notice. If no response is received services may be terminated.
[1.13.20.9 NMAC - Rp, 1 NMAC 3.2.20.3.9, 6/30/2005]

HISTORY OF 1.13.20 NMAC:

History of Repealed Material:
1 NMAC 3.2.20.3, Storage of Electronic Media at the State Records Center and Archives - Repealed 6/30/2005

NEW MEXICO COMMISSION OF PUBLIC RECORDS

This is an amendment to 1.13.2 NMAC, Sections 1, 3, 7, 12, 13 and 20, effective June 30 2005.

1.13.2.1 ISSUING AGENCY: [~~New Mexico~~] State Commission of Public Records - State Records Center and Archives.
[7/1/95; 1.13.2.1 NMAC - Rn, 1 NMAC 3.100.1 & A, 3/14/01; A, 6/30/05]

1.13.2.3 STATUTORY AUTHORITY: Statutory authority for 1.13.2 NMAC is found in Chapter 14, Article 3, NMSA 1978. Specifically, Section 14-3-6 NMSA 1978 authorizes the state records administrator to adopt regulations. Section 14-3-15.1 NMSA 1978 provides for the payment of reasonable fees for the service of providing information contained in information databases by the agency that inserted the information. It further mandates the assessment of a fee by the agency providing access or use where information contained in a database is "searched, manipulated, or retrieved or a copy of the database is made for any private nonpublic use." The section also authorizes the imposition of certain conditions on the use of such information or databases. Section 14-3-8.1 creates the records center revolving

fund, in which money from the sale of "publications, services, equipment, supplies and materials" is deposited. Section 14-3-19 NMSA 1978 allows the state commission of public records to sell certain items and services at a cost plus five percent handling charge. All receipts from such sales go into the records center revolving fund.
[7/1/95; 1.13.2.3 NMAC - Rn, 1 NMAC 3.100.3 & A, 3/14/01; A, 7/15/03; A, 6/30/05]

1.13.2.7 DEFINITIONS:

A. "Acid-free" means having a pH of 7.0 or greater.

B. "Archival" means the material properties inherent in any medium permitting its preservation under controlled conditions.

C. "Certified copy" means a reproduction of a public record expressly verified by the custodial agency as a true and accurate representation of the official copy of the record.

D. "Clip" means a selected part of a motion picture film.

[~~D.~~] **E.** "Digital restoration" means digitally improving the overall appearance of a scanned photograph by adjusting brightness or contrast or both, sharpening, adjusting overall color, cropping, etc.

[~~E.~~] **F.** "Enhancement" means digitally repairing a scanned photograph to remove signs of deterioration and damage (spots, tears, red eye, fold lines, etc.).

[~~F.~~] **G.** "Record" means all books, papers, maps, photographs, recordings, tapes or other documentary materials, regardless of physical form or characteristics.

[~~G.~~] **H.** "SRCA" means the state records center and archives.
[1.13.2.7 NMAC - N, 3/14/01; A, 7/15/03; A, 6/30/05]

1.13.2.12 MICROPHOTOGRAPHY FEES:

A. Microfilm to paper copies.

(1) 8 ½ x 11 - $0.50

(2) 8 ½ x 14 - $0.60

B. Self-service microfilm to paper copies.

(1) 8 ½ x 11 - $0.10

(2) 8 ½ x 14 - $0.10

(3) 11 x 14 - $0.15

[~~C. Microfilm duplication - agency masters.~~

~~(1) 16mm - $11.00 per reel~~

~~(2) 35mm - $12.00 per reel~~]

[~~D.~~] **C.** Microfilm duplication [~~services - archival collections~~].

(1) 16mm - $12.00 per reel

(2) 35mm - $16.00 per reel

[~~E.~~] **D.** Compact disk duplication services - archival collections.

(1) Land records of New Mexico (Spanish archives of New Mexico I - SANM I) - $1,250.00

(2) Spanish archives of New Mexico II (SANM II) - $250.00

(3) Translations - $125.00

(4) Mexican archives of New Mexico (MANM) - $725.00

(5) Territorial archives of New Mexico (TANM) - $7,340.00

(6) Sender Collection - $50.00

[~~F. Microfilm processing, 16mm and 35mm - $19.85 per reel~~]

E. Microfilm services.

(1) Technical consultation and assistance - $10.00 per hour with a minimum charge of one hour

(2) Document preparation - $10.00 per hour with a minimum charge of one hour, plus cost of supplies

(3) Microfilming - $0.35 per image

(4) Microfilm processing, 16 mm and 35 mm - $19.85 per reel

(5) Step-test analysis - $5.00 per analysis
[7/1/95, 9/15/98, 12/15/98; 1.13.2.12 NMAC - Rn, 1 NMAC 3.100.10 & A, 3/14/01; A, 4/30/02; A, 6/30/04; A, 6/30/05]
[Of the items listed under Subsection D, above, only the *Translations* are available as of April 2002; others are scheduled for completion in Fiscal Year 2006. Also, item costs cited under Subsection D are for the collections. For costs for partial collections, see 1.13.2.17 NMAC, *Electronic Copies of Records*.]

1.13.2.13 PHOTOGRAPH AND MOTION PICTURE FILM REPRODUCTION:

A. Requests for duplication and reproduction of photographs and film that are covered under Section 14-3-15.1 NMSA 1978 or are copyrighted or otherwise contractually restricted shall be accompanied by a letter of intent describing the proposed use and SRCA form 96-18 "conditions for publication/reproduction."

B. Prints from digital images.

(1) 5 x 7 - $12.00

(2) 8 x 10 - $12.00

C. Video copies.

(1) Video cassette-to-video cassette copies - $30.00

(2) Motion picture film-to-video cassette copies - $47.50

[~~(2)~~] **(3)** ¾ in. broadcast tape, 30 min - $50.00

[~~(3)~~] **(4)** ¾ in. broadcast tape, 60 min. - $60.00

D. Where items are fragile or require specialized handling, the SRCA may charge the costs of the additional labor.

E. Fees for digital restoration or enhancement [~~of a scanned photograph~~] or clip selection of digitized materials or motion picture films vary according to the extent of work required. The minimum fee for digital restoration or enhancement or clip selection shall be $15.00 per [~~image~~] reproduced item, in addition to the reproduction fee set forth in Subsection B of this section. For work requiring over one hour, $15.00 per additional hour shall be charged.
[7/1/95, 4/30/96, 12/15/98; 1.13.2.13 NMAC - Rn, 1 NMAC 3.100.11 & A, 3/14/01; A, 4/30/02; A, 7/15/03; A. 6/30/05]

1.13.2.20 RECORDS STORAGE SERVICES:

A. State agency records, paper.

(1) Records that have not met their legal retention or that have been subpoenaed or are otherwise involved in ongoing litigation or an active investigation - no charge

(2) Records that have met their legal retention and for which the SRCA has issued a destruction notice - $0.25 per month per box (see 1.13.10 NMAC)

B. Municipal and county records, paper - $0.25 per box (either cubic-foot or maps and drawings box) per box, regardless of whether retention has been met (see 1.13.2 NMAC).

C. State agency records, microfilm.

(1) Records that have not met their legal retention or that have been subpoenaed or are otherwise involved in ongoing litigation or an active investigation - no charge

(2) Records that have met their legal retention and for which the SRCA has issued a destruction notice - $0.04 per 16mm roll equivalent per month (see 1.13.10 NMAC)

D. Municipal and county records, microfilm - $0.04 per 16mm roll equivalent per month, regardless of whether retention has been met (see 1.13.10 NMAC).
[1.13.2.20 NMAC - N, 6/30/05]
[The SRCA is not, as of the effective date of this section, imposing fees for the storage of electronic records.]

NEW MEXICO COMMISSION OF PUBLIC RECORDS

This is an amendment to 1.13.5 NMAC, Sections 1, 3, 6, 7, 10, 14 and 17, effective June 30, 2005.

1.13.5.1 ISSUING AGENCY: [~~New Mexico Commission of Public Records - New Mexico Historical Records Advisory Board (NMHRAB)~~] State

Commission of Public Records - State Records Center and Archives.
[1.13.5.1 NMAC - N, 11/30/00; A, 06/30/05]

1.13.5.3 STATUTORY AUTHORITY: Public Records Act [~~, Chapter 14, Article 3~~] 14-3-6 NMSA 1978 and 44 U.S.C.25, 36 CFR 1206[~~, CFDA Section 89.003~~].
[1.13.5.3 NMAC - N, 11/30/00; A, 06/30/05]

1.13.5.6 OBJECTIVE: [~~The NMHRAB~~] The New Mexico historical records advisory board (NMHRAB) has received funds from the New Mexico legislature and the national historic publications and records commission (NHPRC) to fund its historical records grant programs for improving preservation of and access to New Mexico's historical records. To address funding issues that underlie many other problems identified during its strategic planning process, the NMHRAB created its grant program. Subject to funding availability, grants shall be awarded annually to applicants who demonstrate need, financially and programmatically, and show commitment to solving their historical records problems. Projects shall address the funding priorities of the NMHRAB as published.
[1.13.5.6 NMAC - N, 11/30/00; A, 06/30/04; A, 06/30/05]

1.13.5.7 DEFINITIONS:

A. "Access" means the availability of archives, records or manuscripts in terms of physical condition, legal permission, and intellectual entry.

B. "Accession" means a term used as both a noun and a verb for the act and procedures involved in a transfer of legal title and the taking of records or papers into the physical custody of an archival agency, records center or manuscript repository and the materials involved in such a transfer.

C. "Archives" means the non-current records of an organization or institution preserved because of their continuing value in meeting the needs of the creating organization.

D. "Archivist" means an employee whose duty is to maintain the non-current records of an organization or agency in order to serve its needs. Evidence of advanced study in an applicable academic area is usually required.

E. "Arrangement of collections" means the process and results of organizing records or manuscripts, particularly by function or activity of their creator.

F. "Collection policy" means a statement adopted by an archival agency, records center or manuscript repository to guide its accessioning and de-accessioning decisions in order to carry out its formal mission.

G. "Cubic feet" means a standard measure of the quantity of archival material; the term refers to the amount of space usually occupied by one standard records storage box (12 in. x 12 in. x 16 in.) on standard archival shelving. By conversion, 36 inches of letter-size papers, arranged lineally (three linear feet), would occupy approximately two cubic feet, if placed in storage boxes.

H. "Curator" means an employee whose duty is to foster research by making accessible order of a repository's collections. Evidence of advanced study in an applicable academic area is usually required.

I. "De-accession" means the act, or the materials involved in the act, of a transfer out of the custody of an archives and is the opposite of accession.

J. "Documentary edition" means a published edition of documents derived directly from original records and often accompanied by editorial commentary and annotations.

K. "Essential minimum" means, in the interests of efficiency and economy, the most succinct statements and the most definitive examples that meet the application requirements, thus keeping the proposal package simple, focused and relevant. For example, resumes, which provide the essential minimum, are more impressive by their relevance than by their length.

L. "Evaluation" means a mechanism by which the effectiveness of the project can be measured by describing the extent to which a project's goals have been met. Narrative, graphic or statistical methods can be used to assess the product or to analyze the process. Participant or user assessments are also helpful in some cases.

M. "Finding aid" means a descriptive device created by an archives, records center or repository to establish the size, condition, content or arrangement of a collection or record group.

N. "Fiscal agent" means the financial representative of a corporation or service organization, or the officer authorized to make financial transactions.

O. "Mission statement" means a formal, written statement of an organization's or agency's purpose or vision. Non-profit organizations normally provide a mission statement when registering with the New Mexico public regulation commission.

P. "Non-profit organization" means any organization, which by its articles of association and by-laws prohibits acts of private inurement, that is, transferring of the organization's earnings to persons in their private capacity; non-profit organizations are required to use their earnings for their program activities and these earnings are tax-exempt if the organization has met the approval of the internal revenue service as falling within a category such as 501(c) (3).

Q. "Original records" means archives or public records as created by a governmental or quasi-governmental body, and manuscripts such as letters, diaries, photographs or other first-hand reports.

R. "Preservation" means the provision of adequate facilities for the protection, care and maintenance of archives, records, and manuscripts, particularly to promote their future availability.

S. "Provenance" means the source or the office of origin of the records and thus the principle of maintaining the integrity of the records' identity by their creator and, also, respect for their original order.

T. "Qualified individuals" means an archivist, curator, librarian or records manager.

U. "Records manager" means an employee whose duty is to manage the creation, use and disposition of an organization or agency's records. Evidence of advanced study in an applicable academic area is usually required.

V. "Statement of need" means a logical and succinct presentation of the argument for the necessity of a project; it should be factual, reasonable and persuasive.

W. "Underserved community" means populations in which individuals lack access to programs due to geography, economics, ethnicity, disability, or age.
[1.13.5.7 NMAC - N, 11/30/00; A, 06/30/04; A, 06/30/05]

1.13.5.10 FUNDING PRIORITIES: Grant funds shall be ranked according to funding priorities adopted by the NMHRAB.

A. Training programs or opportunities for historical records' custodians to develop basic management tools for the care and preservation of records in their custody.

B. Assessment or survey of records that are in public and private repositories that results in developing or enhancing a repository's records or archival management program.

C. Development of tribal records management and archival programs.

D. Identification and mitigation of at-risk historical records in public and private repositories (activities may include preservation and conservation processes needed to stabalize the media on

which records are captured in accordance with an approved conservation plan).

E. Preservation activities that include but are not limited to reformatting (microfilm, copying to permanent media, etc) and re-housing.

F. Projects that facilitate access to New Mexico's historical records through activities that include but are not limited to cataloging, creating finding aids, digitizing (shall include an appropriate index) and organizing collections.

G. Documentary research based on original records that results in publication or dissemination.

H. Programs that promote New Mexico's history through its historical records with activities that include exhibits, conferences, papers and documentaries.

I. Previously unfunded applicants and applicants from small or underserved communities.

[1.13.5.10 NMAC - N, 11/30/00; 07/15/03; A, 06/30/04; A, 06/30/05]

1.13.5.14 APPLICATION FOR HISTORICAL RECORDS GRANTS:

A. An applicant shall answer all questions on the application form. An applicant may submit pertinent attachments to support its application, but the number of pages shall be limited to the essential minimum. An applicant shall submit one completed application with original signatures and supporting documents, and eight copies. Incomplete applications shall not be considered.

B. The following information shall be included in the application.

(1) Applicant information - legal name, address, contact name, phone number and e-mail address.

(2) Signature by an individual authorized to obligate the applicant.

(3) Fiscal agent's name, title and address.

(4) Project title, period and amount of both the grant request and the proposed match.

(5) Applicant's status:

(a) An organization shall be an eligible entity as defined in Subsection A of 1.13.5.8 NMAC.

(b) An individual shall be legally affiliated with the qualifying organization or repository and professionally engaged in work applicable to the historical records community; or registered as a business within the state of New Mexico whose work will result in documentary editions or will benefit historical records repositories generally, and whose credentials meet the standards set by the NMHRAB.

(6) A copy of the organization's formally adopted statement of mission or purpose.

(7) A copy of the organization's collection management policy (unless establishing one is the objective of the proposal).

(8) A summary statement that briefly summarizes the nature and purpose of the project proposed for funding no more than one-quarter page in length.

(9) A project description narrative limited to three pages in length. The narrative shall discuss content and significance of the historical records to be affected by this project, the scope of the work to be performed, key personnel and the work plan for the project.

(10) The budget for the project submitted on the form prescribed by the NMHRAB.

[~~C. Project period: Funded projects shall be completed within one year from date specified in award letter.~~]

[~~D.~~] C. Application deadline: Completed applications (original and eight copies) shall be received by the deadline set forth in the call for proposals.

[~~E.~~] D. Rejection: Applications that do not comply with these criteria shall be rejected.

[1.13.5.14 NMAC - N, 11/30/00; A, 09/30/02; A, 07/15/03; A, 06/30/04; A, 06/30/05]

1.13.5.17 POST-AWARD REQUIREMENTS: Successful historical record grant applicants shall comply with the following post award requirements.

A. Submit progress reports halfway through the project.

B. Submit final reports within 60 days of project completion.

C. Request funds on a reimbursement basis and no more than 50 percent before substantial completion of the work.

D. Submit proof of completion of training before project start date, if required.

E. Adhere to the State Procurement Code for purchase of goods and services.

F. Maintain grant records for at least two years after completion of the project.

G. Submit an article to the NMHRAB office for possible publication in agency newsletter, the Quipu or other publication.

H. Project period: Funded projects shall be completed within one year from date specified in award letter.

[1.13.5.16 NMAC Rn to 1.13.5.17 NMAC & A, 09/30/02; A, 06/30/04; A, 06/30/05]

NEW MEXICO COMMISSION OF PUBLIC RECORDS

1 NMAC 3.2.70.1, Performance Guidelines for the Legal Acceptance of Public Records Produced by Information Technology Systems, filed 4-21-97, has been reformatted and renumbered to 1.13.70 NMAC to comply with the current NMAC requirements, effective 6-30-05.

NEW MEXICO COMMISSION OF PUBLIC RECORDS

1 NMAC 3.2.60.3, Microphotography Equipment: Inventory and Transfer, filed 4-18-97, has been reformatted and renumbered to 1.14.3 NMAC to comply with the current NMAC requirements, effective 6-30-05.

NEW MEXICO WATER QUALITY CONTROL COMMISSION

Explanatory Paragraphs: This is an amendment to 20.6.4.7, 20.6.4.9, 20.6.4.15 and 20.6.4.900 NMAC, effective 07-17-05.

The Water Quality Control Commission (WQCC) identified typographical and other nonsubstantive errors that occurred in the version of the rule filed with the State Records Center on April 21, 2005 and published in the New Mexico Register on May 13 2005 (Volume XVI, Number 9).

The errors occur in Subsections E and ZZ of 20.6.4.7 NMAC, Paragraph (2) of Subsection B of 20.6.4.9 NMAC, Paragraph (4) of Subsection D of 20.6.4.15 NMAC, Subsection E of 20.6.4.15 NMAC and Subsection (J) of 20.6.4.900 NMAC.

The corrected language for 20.6.4.7, 20.6.4.9 and 20.6.4.15 NMAC provided below was approved by the WQCC during its deliberations and is contained within the final Statement of Reasons.

The deletion of the CAS number for "DDT and derivatives" in Subsection J of 20.6.4.900 NMAC was within the proposed rulemaking and approved by the WQCC, but inadvertently not stricken in the filed version of the rule or the Statement of Reasons.

The corrections to the criteria for livestock watering and wildlife habitat in Subsection J of 20.6.4.900 NMAC provided below are

necessary because NMED staff inadvertently included the livestock watering criteria and habitat criteria in the final version for WQCC approval, however the revisions had been withdrawn from consideration before the public hearing was held and should not have been included.

The amendments to the affected subsections follow:

20.6.4.7 D E F I N I T I O N S: Terms defined in the New Mexico Water Quality Act, but not defined in this part will have the meaning given in the Water Quality Act.

E. "Best management practices" or "BMPs":

(1) for national pollutant discharge elimination system (NPDES) permitting purposes means schedules of activities, prohibitions of practices, maintenance procedures and other management practices to prevent or reduce the pollution of "waters of the United States;" BMPs also include treatment requirements, [~~operation~~] operating procedures and practices to control plant site runoff, spillage or leaks, sludge or waste disposal or drainage from raw material storage; or

(2) for nonpoint source pollution control purposes means methods, measures or practices selected by an agency to meet its nonpoint source control needs; BMPs include but are not limited to structural and nonstructural controls and operation and maintenance procedures; BMPS can be applied before, during and after pollution-producing activities to reduce or eliminate the introduction of pollutants into receiving waters; BMPs for nonpoint source pollution control purposes shall not be mandatory except as required by state or federal law.

ZZ. "Segment" means a classified surface water of the state described in 20.6.4.101 through 20.6.4.899 NMAC. The water within a segment should have the same uses, similar hydrologic characteristics or flow regimes, and natural physical, chemical and biological characteristics and exhibit similar reactions to external stresses, such as the discharge of pollutants.

20.6.4.9 O U T S T A N D I N G NATIONAL RESOURCE WATERS:

B. Criteria for ONRWs: A surface water of the state, or a portion of a surface water of the state, may be designated as an ONRW where the commission determines that the designation is beneficial to the state of New Mexico, and:

(1) the water is a significant attribute of a state gold medal trout fishery, national or state park, national or state monument, national or state wildlife refuge or designated wilderness area, or is part of a designated wild river under the federal Wild and Scenic Rivers Act; or

(2) the water has exceptional recreational or ecological significance; or

(3) the existing water quality is equal to or better than the numeric criteria for protection of aquatic life uses, recreational uses and human health uses, and the water has not been significantly modified by human activities in a manner that substantially detracts from its value as a natural resource.

20.6.4.15 USE ATTAINABILITY ANALYSIS:

D. A use attainability analysis or equivalent study should include:

(1) identification of existing uses of the surface water of the state to be reviewed that have existed since 1975;

(2) an evaluation of the best water quality attained in the surface water of the state to be reviewed that has existed since 1975;

(3) an analysis of appropriate factors demonstrating that attaining the designated use is not feasible because of the condition listed in 40 CFR Part 131.10(g);

(4) a physical evaluation of the surface water of the state to be reviewed to identify factors that impair attainment of designated uses and to determine [~~that~~] which designated uses are feasible to attain in such surface water of the state;

(5) an evaluation of the water chemistry of the surface water of the state to be reviewed to identify chemical constituents that impair the designated uses that are feasible to attain in such water; and

(6) an evaluation of the aquatic and terrestrial biota utilizing the surface water of the state to determine resident species and which species could potentially exist in such water if physical and chemical factors impairing a designated use are corrected.

E. Any person may submit notice to the department stating that they intend to conduct a use attainability analysis or equivalent study. The proponent shall develop a work plan to conduct the use attainability analysis or equivalent study and shall submit the work plan to the department and the regional EPA staff for review and comment. The work plan should identify the scope of data currently available and proposed to be gathered, the factors affecting use attainment that will be analyzed and must contain provisions for public notice and consultation with appropriate state and federal agencies. A copy of the notice and the work plan must be submitted concurrently to the commission. Upon approval of the work plan by the department, the proponent shall conduct the use attainability analysis or equivalent study in accordance with the approved work plan. The cost of such analysis or equivalent study shall be the responsibility of the proponent. Upon completion of the use attainability analysis or equivalent study, the proponent shall submit the [~~date~~] data, findings and conclusions to the department and the commission.

20.6.4.900 CRITERIA APPLICABLE TO ATTAINABLE OR DESIGNATED USES UNLESS OTHERWISE SPECIFIED IN 20.6.4.97 THROUGH 20.6.4.899 NMAC.

J. Numeric criteria. The following table sets forth the numeric criteria adopted by the commission to protect existing, designated and attainable uses. Additional criteria that are not compatible with this table are found in Subsections A through I of this section.

[Continued on page 652.]

Pollutant total, unless indicated	CAS Number	Domestic Water Supply µg/L unless indicated	Irrigation µg/L unless indicated	Livestock Watering µg/L unless indicated	Wildlife Habitat µg/L unless indicated	Aquatic Life		Human Health µg/L	Cancer Causing (C) or Persistent (P)
						Acute µg/L	Chronic µg/L		
Aluminum, dissolved	7429-90-5		5,000	[~~5,000~~]		750	87		
[~~Aluminum~~]	[~~7429-90-5~~]			[~~500~~]					
Antimony, dissolved	7440-36-0	5.6						640	P
Arsenic, dissolved	7440-38-2	2.3	100	200		340	150	9.0	C,P
[~~Arsenic~~]	[~~7440-38-2~~]			[~~20~~]					
Asbestos	1332-21-4	7,000,000 fibers/L							
Barium, dissolved	7440-39-3	2,000							
[~~Barium~~]	[~~7440-39-3~~]			[~~10 mg/L~~]					
Beryllium, dissolved	7440-41-7	4							
Boron, dissolved	7440-42-8		750	5,000					
Cadmium, dissolved	7440-43-9	5	10	50		see 20.6.4.900.I	see 20.6.4.900.I		
[~~Cadmium~~]	[~~7440-43-9~~]			[~~5~~]					
Chlorine residual	7782-50-5				11	19	11		
Chromium, dissolved	18540-29-9	100	100	1,000		see 20.6.4.900.I	see 20.6.4.900.I		
Cobalt, dissolved	7440-48-4		50	1,000					
Copper, dissolved	7440-50-8	1300	200	500		see 20.6.4.900.I	see 20.6.4.900.I		
Cyanide, dissolved	57-12-5	200							
Cyanide, weak acid dissociable	57-12-5	700			5.2	22.0	5.2	220,000	
[~~Fluoride~~]				[~~2 mg/L~~]					
Lead, dissolved	7439-92-1	50	5,000	100		see 20.6.4.900.I	see 20.6.4.900.I		
[~~Lead~~]	[~~7439-92-1~~]			[~~15~~]					
Mercury	7439-97-6	2		10	0.77				
Mercury, dissolved	7439-97-6				[~~0.77~~]	1.4	0.77		
Methymercury	22967-92-6							0.3 mg/kg in fish tissue	P
Molybdenum, dissolved	7439-98-7		1,000						
Nickel, dissolved	7440-02-0	100				see 20.6.4.900.I	see 20.6.4.900.I	4,600	P
[~~Nickel~~]	[~~7440-02-0~~]			[~~250~~]					
Nitrate as N		10 mg/L							
Nitrite + Nitrate				132 mg/L					

Selenium, dissolved	7782-49-2	50	see 20.6.4.900.C	50				4,200	P
Selenium, total recoverable	7782-49-2				5.0	20.0	5.0		
Silver, dissolved	7440-22-4					see 20.6.4.900.I			
Thallium, dissolved	7440-28-0	1.7						6.3	P
Uranium, dissolved	7440-61-1	5,000							
Vanadium, dissolved	7440-62-2		100	100					
Zinc, dissolved	7440-66-6	7,400	2,000	25,000		see 20.6.4.900.I	see 20.6.4.900.I	26,000	P
[~~Zinc~~]	[~~7440-66-6~~]			[~~5 mg/L~~]					
Adjusted gross alpha (see 20.6.4.900.B and .F)		15 pCi/L		15 pCi/L					
Radium 226 + Radium 228		5 pCi/L		30.0 pCi/L					
Strontium 90		8 pCi/L							
Tritium		20,000 pCi/L		20,000 pCi/L					
Acenaphthene	83-32-9	670						990	
Acrolein	107-02-8	190						290	
Acrylonitrile	107-13-1	0.51						2.5	C
Aldrin	309-00-2	0.00049				3.0		0.00050	C,P
Anthracene	120-12-7	8,300						40,000	
Benzene	71-43-2	22						510	C
Benzidine	92-87-5	0.00086						0.0020	C
Benzo(a)anthracene	56-55-3	0.038						0.18	C
Benzo(a)pyrene	50-32-8	0.038						0.18	C,P
Benzo(b)fluoranthene	205-99-2	0.038						0.18	C
Benzo(k)fluoranthene	207-08-9	0.038						0.18	C
alpha-BHC	319-84-6	0.026						0.049	C
beta-BHC	319-85-7	0.091						0.17	C
Gamma-BHC (Lindane)	58-89-9	0.19				0.95		0.63	C
Bis(2-chloroethyl) ether	111-44-4	0.30						5.3	C
Bis(2-chloroisopropyl) ether	108-60-1	1,400						65,000	
Bis(2-ethylhexyl) phthalate	117817	12						22	C
Bromoform	75-25-2	43						1,400	C
Butylbenzyl phthalate	85-68-7	1,500						1,900	
Carbon tetrachloride	56-23-5	2.3						16	C

Chlordane	57-74-9	0.0080				2.4	0.0043	0.0081	C,P
Chlorobenzene	108-90-7	680						21,000	
Chlorodibromomethane	124-48-1	4.0						130	C
Chloroform	67-66-3	57						4,700	C
2-Chloronaphthalene	91-58-7	1,000						1,600	
2-Chlorophenol	95-57-8	81						150	
Chrysene	218-01-9	0.038						0.18	C
4,4'-DDT and derivatives	[~~50-29-3~~]	0.0022			0.001	1.1	0.001	0.0022	C,P
Dibenzo(a,h)anthracene	53-70-3	0.038						0.18	C
Dibutyl phthalate	84-74-2	2,000						4,500	
1,2-Dichlorobenzene	95-50-1	2,700						17,000	
1,3-Dichlorobenzene	541-73-1	320						960	
1,4-Dichlorobenzene	106-46-7	400						2,600	
3,3'-Dichlorobenzidine	91-94-1	0.21						0.28	C
Dichlorobromomethane	75-27-4	5.5						170	C
1,2-Dichloroethane	107-06-2	3.8						370	C
1,1-Dichloroethylene	75-35-4	0.57						32	C
2,4-Dichlorophenol	120-83-2	77						290	
1,2-Dichloropropane	78-87-5	5.0						150	C
1,3-Dichloropropene	542-75-6	10						1,700	
Dieldrin	60-57-1	0.00052				0.24	0.056	0.00054	C,P
Diethyl phthalate	84-66-2	17,000						44,000	
Dimethyl phthalate	131-11-3	270,000						1,100,000	
2,4-Dimethylphenol	105-67-9	380						850	
2,4-Dinitrophenol	51-28-5	69						5,300	
2,4-Dinitrotoluene	121-14-2	1.1						34	C
2,3,7,8-TCDD Dioxin	1746-01-6	5.0E-08						5.1E-08	C,P
1,2-Diphenylhydrazine	122-66-7	0.36						2.0	C
alpha-Endosulfan	959-98-8	62				0.22	0.056	89	
beta-Endosulfan	33213-65-9	62				0.22	0.056	89	
Endosulfan sulfate	1031-07-8	62						89	
Endrin	72-20-8	0.76				0.086	0.036	0.81	
Endrin aldehyde	7421-93-4	0.29						0.30	
Ethylbenzene	100-41-4	3,100						29,000	
Fluoranthene	206-44-0	130						140	
Fluorene	86-73-7	1,100						5,300	
Heptachlor	76-44-8	0.00079				0.52	0.0038	0.00079	C
Heptachlor epoxide	1024-57-3	0.00039				0.52	0.0038	0.00039	C
Hexachlorobenzene	118-74-1	0.0028						0.0029	C,P
Hexachlorobutadiene	87-68-3	4.4						180	C
Hexachlorocyclopentadiene	77-47-4	240						17,000	
Hexachloroethane	67-72-1	14						33	C

Ideno(1,2,3-cd)pyrene	193-39-5	0.038						0.18	C
Isophorone	78-59-1	350						9,600	C
Methyl bromide	74-83-9	47						1,500	
2-Methyl-4,6-dinitrophenol	534-52-1	13						280	
Methylene chloride	75-09-2	46						5,900	C
Nitrobenzene	98-95-3	17						690	
N-Nitrosodimethylamine	62-75-9	0.0069						30	C
N-Nitrosodi-n-propylamine	621-64-7	0.050						5.1	C
N-Nitrosodiphenylamine	86-30-6	33						60	C
PCBs	1336-36-3	0.00064			0.014		0.014	0.00064	C,P
Pentachlorophenol	87-86-5	2.7				19	15	30	C
Phenol	108-95-2	21,000						1,700,000	
Pyrene	129-00-0	830						4,000	
1,1,2,2-Tetrachloroethane	79-34-5	1.7						40	C
Tetrachloroethylene	127-18-4	6.9						33	C,P
Toluene	108-88-3	6,800						200,000	
Toxaphene	8001-35-2	0.0028				0.73	0.0002	0.0028	C
1,2-Trans-dichloroethylene	156-60-5	700						140,000	
1,2,4-Trichlorobenzene	120-82-1	260						940	
1,1,2-Trichloroethane	79-00-5	5.9						160	C
Trichloroethylene	79-01-6	25						300	C
2,4,6-Trichlorophenol	88-06-2	14						24	C
Vinyl chloride	75-01-4	20						5,300	C

End of Adopted Rules Section

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